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AMNESIC STATES IN WAR NEUROSES: THE PSYCHOGENESIS OF FUGUES

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Amnesic states occur with great frequency in war neuroses, both in individuals who have seen active combat and in those faced with the threat of battle experience. Torrie *(1)* found that amnesia, including fugue, occurred in eight and six tenths percent of one thousand cases of anxiety neuroses and hysteria which developed in one of the African campaigns. Henderson and Moore *(2)*, reporting two hundred neurosychiatric patients studied in the South Pacific, found that five percent who had seen combat had an amnesia for the event. They also noted that fifty percent of their combat cases were rendered unconscious and that many of these had amnesia after regaining consciousness. Grinker and Spiegel *(3)* have likewise called attention to the frequency with which fugues and fuguelike states occurred during the Tunisian campaign.

Although these states are so common under military conditions, as well as in civilian life, it is worthy of note that in the psychiatric and psychoanalytic literature few detailed studies from the point of view of psychodynamics have appeared. In his Outline of Clinical Psychoanalysis, Fenichel *(4)* does not even mention fugues. This neglect of the study of amnesic states is especially deplorable since psychoanalysis is so much concerned with distortions of memory that one might presuppose a concomitant interest in the specific diseases of memory. Perhaps the chief reason for this neglect on the part of psychoanalysis is that patients suffering from amnesic states,

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especially the various types of fugue, are rarely treated by analysts during the period of their illness. Civilians suffering from fugues are frequently seen in general hospitals or large urban psychopathic hospitals, but there is generally little opportunity or incentive to study them in detail. Only recently a group of investigators at the Menninger Clinic, including Geleerd, Hacker, Rapaport and Gill *(5, 5a)*, have begun to study fugues from a psychoanalytic point of view.

During the past two years the author has had occasion to observe and treat twenty patients from the U. S. Coast Guard and the Merchant Marine who were suffering from different types of fugue. It should be emphasized that there are a number of varieties of fugue and that up to the present time the phenomenology of these states has not been worked out with any degree of clarity. This paper will discuss three types of fugue, namely: 1. fugue with 'awareness of loss of personal identity', 2. fugue with change of personal identity, and 3. fugue with retrograde amnesia. It will be chiefly concerned with the psychological meaning and possible function of the memory distortions encountered in these fugue states.

With one exception (case four), all of the patients were treated by hypnosis. The technique of hypnosis utilized has been described elsewhere *(7)*. Because of the exigencies of time the patients were hypnotized no more than four to eight times for periods of about an hour and were under observation for from two to four weeks. In working with these patients it is very important to get a detailed account of the patient's memory disturbance before the treatment is begun. It is necessary to ascertain the exact instant in time when the patient entered the fugue state and the time he emerged from it. Patients can always give this information. A patient will state, for example, 'I walked into the subway and just as I put my nickel in the slot I "blacked out" '. This is important because in attempting to reconstruct the fugue the hypnotized subject is brought back to the occurrences immediately prior to its onset and made to relive them. Almost always, in the

adequately hypnotized subject, the patient will reënact these experiences either in narrative form, or in a vivid, emotional reliving of them, and then go on to describe or reëxperience the events of the fugue itself.

The most important factor in working out the psychodynamics of a fugue is the uncovering of the unconscious fantasies which occur at its onset. It cannot be stressed too much that to understand the psychogenesis of fugue states it is absolutely necessary to explore what was going on in the patient's mind just prior to, during, and immediately after the moment of onset. The hypnotized subject is brought back to this moment either by describing to him in detail the situation he was in at the time, as it was learned from his history, and suggesting to him that he relive it, or by utilizing the age regression technique devised by Erickson *(7)*. While the patient is reviving the experiences of the fugue under hypnosis it is important not to interrupt him by asking questions; it is advisable to be quite passive. If one intervenes in his reënactment at all it is done by playing a rôle so that the patient misidentifies the hypnotist and believes him to be someone who was present during the experiences he is relating.

1. *Fugue with Awareness of Loss of Personal Identity*

In the so-called hysterical fugue the individual suddenly passes into an altered state of consciousness during which he retains enough of his ego structure and is in sufficient contact with reality to give the appearance of a fairly normal person. He is able to perform complex activities, frequently involving travel over long distances (fugue means flight or a lark). Then just as suddenly he will emerge from this altered state of consciousness and seem to be his usual self, but will have a complete amnesia for all the events of the fugue. Rapaport *(5)* has pointed out that the fugue may end in either of two ways: 1. On emerging from the fugue the subject is his usual self, is aware of his personal identity and has full memory of his past life with the exception of the experiences of the fugue.

2. There is a sudden awareness on the part of the subject that he does not know who he is, where he is, or anything about his past life. In other words, he is in a state of 'awareness of loss of personal identity'. The latter state and the fugue appear to be two phases of a single process and the evidence suggests that the state of 'awareness of loss of personal identity' is usually, perhaps always, preceded by a fugue.

Rapaport has suggested that loss of personal identity is present in many fugue states, but the patient does not become aware of it. He has, therefore, made a distinction between 'loss of personal identity' and 'awareness of loss of personal identity'. Although it is felt that the specific categorization of the latter state as a special condition is a distinct advance, the designation of other fugues as showing 'loss of personal identity' without awareness of the loss is confusing. This problem will be discussed later in greater detail.

In treating the state under discussion psychiatrists have usually directed their efforts toward restoring the patient's sense of personal identity, and only rarely, as Rapaport has pointed out, has an attempt been made to recover the memory of the course of the antecedent fugue. It is very important to reconstruct the antecedent fugue to obtain a psychological understanding of these states. Abeles and Schilder *(8)*, who were the first to consider psychogenic loss of personal identity as a separate syndrome, seem to have been aware of the antecedent fugue, but did not attempt to study it. They pointed out that after the restoration of personal identity there is frequently a permanent blank period which is apparently never recalled after recovery. This is the period lasting from the onset of the amnesia to the time when the patient decides to confide his difficulty to someone else. This blank sequence, according to these authors, is occasionally recalled with the help of hypnosis, but more frequently it is not.

The blank sequence undoubtedly represents the fugue which precedes the state of awareness of loss of personal identity. In general it has not been found particularly difficult to reconstruct the antecedent fugue by hypnosis.

Case One: This patient gave a history of four fugues which occurred over a period of about a year and a half. In several of these the patient experienced an awareness of loss of personal identity. It is to be noted that the patient was not observed in any of these periods, nor during the fugue states themselves. At the time of his admission to the hospital and throughout his stay he was in his normal state. However, he had four long gaps in his memory, covering the periods of the fugues.

AB, a twenty-one-year-old soldier in the Australian Army, experienced his first fugue in the latter part of 1942. At that time he was with the Australian Imperial Forces in Africa. One day he was on a raiding party when a swarm of Stuka dive bombers came over. One plane detached itself and dived straight at the truck in which the patient was riding. He remembered trying to aim his gun at the plane, at which instant he 'blacked out'. About thirty-two days later he came to in a hospital in Syria hundreds of miles from where he had started. He had no memory of the events of the intervening thirty-two days, but noted that he 'finished up with a new Australian uniform, and a thousand pounds of Syrian money'. He had no recollection of how he had come into possession of these things. For the sake of brevity an account of his second fugue will be omitted. It occurred in March 1943, lasted for about five weeks, and when it terminated the patient found himself in a hospital in Australia. He remained in the hospital for six months, was then ordered out of the war zone and shipped to Canada. Enroute the ship docked briefly in Panama on January 18, 1944. The patient went ashore to a cabaret; he remembered that he was drinking with a sailor and a girl when he suddenly passed into another fugue which lasted about nine hours. He then came to New York where the ship on which he was a passenger was to remain in port for about three weeks before going on to Canada. He was given leave from February 3 to February 27, 1944. On February 6 he was in a movie looking at a picture which he remarked was all about desert fighting. He again suddenly lapsed into a fugue and did not regain his normal state until twenty-one days later in Dubuque, Iowa.

Since the time of the Stuka dive bombing the patient had a marked fear of all airplanes, and also of thunder which reminded him of gunfire. He had frequently repeated anxiety dreams of an airplane 'coming right at me' and would awaken drenched in sweat.

He also had a false memory of the date of the Stuka attack, confusing it with the date of the death of his parents in a London air raid during the blitz.

When first seen the patient behaved in a very immature and childish fashion. He repeatedly expressed the feeling that his sole desire was to get out of the hospital so that he could join the Canadian Army or any other army to kill Germans. He greatly resented being sent to Canada away from combat zones. He was quite boastful and told how he had bayoneted a wounded Nazi at Dunkirk when he was only sixteen. In actuality the patient had passed through a very difficult and trying period. Both his parents were killed in an air raid during the London blitz in December 1940, and he had taken a vow to avenge them and fight until every Nazi was killed. He had participated in the evacuation at Dunkirk and was with the Australian forces in North Africa. Behind his bravado he was tense, anxious, immature and dependent.

Under hypnosis an attempt was first made to recover the events of his last fugue. He was brought back to the time he was sitting in the movie. It was ascertained that he 'blacked out' at the moment he was watching the picture of a Nazi bayoneting an allied soldier. He immediately entered upon a series of fantasies which went something like this: 'I must leave. I must get away. I won't let them intern me in Canada because then I won't be able to fight any longer. I must go on fighting until every Nazi is killed, as I vowed to myself I would.' He then proceeded to plan in his mind how he would run away and at some remote spot cross the Canadian border, and join the Canadian Army. In a very crafty manner, and with a patently hypocritical expression on his face, he outlined how he would fool everyone by not doing the expected things: he would not cross the Canadian border by way of Niagara, the shortest route, but he would go to Pittsburgh, then to Chicago, and further west still; he would take the bus and not the train, as everyone might expect him to do. These are, in fact, the things he did. He took a bus out of New York, spent some days in Pittsburgh and Chicago, finally winding up in Dubuque, Iowa, hundreds of miles from the Canadian border.

It became clear that the patient was running away from and not toward the Canadian border, that he had an intense fear of active combat and that this fear had been thoroughly repressed. In the movie his anxiety had been revived by the sight of the Nazi with the bayonet. His fear was in severe conflict with the demand of his conscience that he fight until every last Nazi was dead, since he had taken a vow to avenge the death of his parents. But it was precisely the instrument which had caused the death of his parents of which he was most fearful, namely, the bombing plane. It has been noted that the patient had a false memory of the date of the Stuka attack in the African desert, confusing it with the day his parents were killed. When his first fugue was reconstructed the following material was uncovered.

As the Stuka peeled off and came diving toward him, he became paralyzed with fear and his hands froze to his gun. He thought to himself, 'I can't take it. I have to get out of here. I'm yellow; I'm a coward.' He then planned in detail in fantasy how he would obtain money for his projected flight by robbing one of the Arab money changers, and this he actually did. He managed to get on a truck going to the rear. He obtained a considerable sum of money, hired a guide and a camel, and with them crossed the desert. He wandered for hundreds of miles, hiding from the military authorities, and finally ended up in Syria. He got lost in the mountains and in the intense cold he became overwhelmed with drowsiness and fell asleep, almost freezing to death. He was rescued by some French ski troopers and taken to a hospital somewhere in Syria where he came to his normal state of consciousness thirty-two days after the onset of the fugue. It should be noted that at the same time that he was formulating his plan to escape from the Stukas, he became possessed with the idea of obtaining a tommy gun, hiding himself near a German concentration camp he had heard of in Syria, and picking off the prisoners in the camp.

During the reconstruction of the third fugue it became clear that anything which forcibly reminded the patient of the

Luftwaffe was capable of precipitating a fugue. As noted, while he was in Panama the patient went to a cabaret and was sitting at a table drinking. There was a floor show, part of which was a burlesque of the German Army. A man came out on the floor dressed in the uniform of a lieutenant of the *Luftwaffe*. He turned and walked in the general direction of the patient who felt that he was coming straight at him. The patient stood up, immediately 'blacked out' and left the cabaret. He came to about nine hours later in his bunk on the ship.

It is worthy of note that in the first two fugues a striking thing occurred: simultaneously with the expression of fear, the patient began to elaborate plans for continuing his war with the Nazis. In the first instance the self-deception was so skilful that he believed he was running toward the Canadian border to join the army the whole time he was actually running away. This thought it was that dominated and possessed him all through his wanderings. His plan became increasingly bizarre, for eventually he believed that he was headed for a small town in Iowa where he was to be picked up by some Australian fliers and taken to Canada. Interesting, too, is the fact that he took his time, ran around with girls much more than he was in the habit of doing, and generally indulged himself. He even managed to have sexual intercourse although he was normally sexually very inhibited and had had only one or two previous experiences. He remembered that he behaved in a very childish fashion during the days of his fugue. In the fugue which took place in the African desert the patient went through another fantastic compromise with his conscience. Although at first it was clear that he was running away from the Stukas, he very soon came to believe that he was on his way to snipe at the Nazis in the concentration camp and this thought dominated him all through his journey.

In two of his fugues the patient experienced an 'awareness of loss of personal identity'. He stated that while in the fugue he feels wonderful and nothing worries him. He has only one thought in mind: he must get to the Canadian border to join the army or he must get to Syria to snipe at the pris-

oners. It does not occur to him who he is, nor is he concerned about his past life. Interestingly, this patient compared the fugue state to being hypnotized. He said, 'When I am hypnotized I only have one thing in my mind and that is whatever you suggest'. He did not become aware of his loss of personal identity until somebody asked his name. For example, during his last fugue he was not aware that he did not know his name until he got to Pittsburgh when he was questioned by the military police. He then identified himself by his identification tag and his papers, but not from memory. During his flight through the desert to Syria he stated that he was unaware of not knowing his name (for nobody asked him) but he knows now that if he had been asked he could not have told it. He felt that in all his fugues he had lost his personal identity and all knowledge of his past life, but he became aware of this only in two instances during the fugue itself. It is to be noted that when he did become aware of his loss of identity he was not particularly perplexed or worried as many seem to be.

The patient was made to remember all that he had divulged under hypnosis, and thus began to become aware of his fear although he was very reluctant to realize it. In an attempt to allay his very strict conscience, the following technical manœuvre was used. While hypnotized he was told that during the night 'things would rearrange themselves in his mind', that as he slept he would come to recognize that he had his amnesic episodes because he was afraid and could not admit it; that this would become acceptable to him; that there was no shame in being afraid; that he was making excessive demands on himself; and that when he awoke in the morning all this would be clear to him. The following morning he was quite remarkably transformed. He appeared more sober, less silly and immature, and he was able to face and accept his fear. He gradually gave up the idea of fighting the Nazis and with every indication of relief agreed that it was best for him to stay out of combat zones. He also became free of the terrifying nightmares of being dive-bombed and lost much of his tension and

irritability. A left-sided hypæsthesia which had been present was gone. Very brief therapy of this type, of course, does not alter fundamental character structure. Memory is restored, some insight into the psychogenesis of the fugue is gained and with it considerable subjective relief. Our insufficient follow-up does not warrant conclusions as to the possibilities of relapse. It is the author's impression that in some cases, at least, relapses occur—even when the patient appears to have insight—if he is put back into the kind of situation which originally provoked the anxiety.

Case Two: CD, an eighteen-year-old colored coastguardman, was admitted to the hospital in a state of 'awareness of loss of personal identity'. He did not know his name, anything about his family, how he happened to be in uniform or any of the details of his past life. When first seen he seemed somewhat confused, although he could converse rationally. He was very perplexed over his loss of memory and was making strenuous efforts to remember but without success. He was first seen at 5:30 A.M. and the following is all that he could remember. Early the previous evening he was sitting on the grass in a park; he was holding a horse by the reins and he concluded that he must have gone horseback riding. Presently he was approached by a white man, a sailor, and his girl. He took it for granted that he had been with them, although he had no memory of it. They all got into a cab and went to the center of the town, where they went bowling, then to a bar and finally to a movie. He remembered that he paid all the bills. There was a double feature in the movie, one picture being a mystery and the other 'about murder'. He fell asleep during the latter picture. When he awoke he found himself alone walking out of the movie; he felt sleepy. He walked down the street and entered a bar. Immediately he felt that somebody was staring at him. It was the sailor with whom he had been, but curiously now dressed in civilian clothes and looking older. The patient had the impression, in an obscure way, that this man was a doctor. But what struck him forcibly was a strange look in his eyes, as though he could look right through him. The patient became afraid and walked out of the bar. He then had the feeling that he was being followed by this man, and upon turning around he felt sure that he saw him. He stopped and asked somebody if he was being followed

and was told no, but he could still see the man standing behind him. He approached a shore patrol for help and when they asked him his name he became aware for the first time that he knew neither his name, where he was stationed, nor anything about himself. He was taken to a civilian hospital and then transferred to this facility, where he was interviewed immediately upon admission.

This patient was hypnotized on four occasions and his fugue completely reconstructed. Upon passing into his first trance he immediately regained his identity and the memory of his past life. He related the events preceding his fugue and of the fugue itself. This was told in the past tense in part, but in the main he relived his experiences just as they had happened and with intense emotion.

In the late afternoon of the day before admission to the hospital, he obtained liberty from his station and went to the city intending to go horseback riding. In the center of town he met the sailor, whom we will call X, and his girl friend, Y. The patient had known X prior to this meeting; they had been stationed together some months previously in a town in the South and had been on somewhat friendly terms. X seemed glad to see him and suggested that all three go riding together. This they did, but the patient noticed that X and Y were always either behind him or in front of him, and he began to feel that X would not ride with him because of his color. He also became aware that the girl was very friendly and had no objection to his company. He was, by the way, a light mulatto, quite handsome and intelligent, and with considerable charm. He began to feel hurt and finally said to X, 'What am I, a stepchild? '. X then retorted amiably but quite seriously that the girl would not ride with a Creole. In disgust the patient left them, dismounted, and sat on the grass brooding over the treatment he had received from X. Later X and Y returned and he went along with them.

The three left the park and spent the evening together. Wherever they went X forced the patient into a position where he had to pay the bills, so that before the night was over he had spent over thirty dollars. All through the evening X made

slighting remarks about him; the patient felt that X was afraid of having his girl taken away from him. He began to feel increasingly angry at X and more and more humiliated. He began in fact to have fantasies of taking the sailor's girl away and of getting the sailor in an alley and beating him. He was especially humiliated because X was quite willing to have him foot all the bills but showed a reluctance to sharing his company.

Finally, they all went to a movie where the following drama ensued: the patient sat on the right of the girl, who seemed quite willing to sit with him, but X sat six seats to her left and thus forced her to get up and sit next to him which left the patient alone. During the movie when X got up and went out for a short while, the girl moved over, sat next to the patient, and began to converse with him. X shortly returned, became furious at the situation, and insisted that the girl either come with him or stay with the patient. There was nothing left for her to do but leave. The patient was infuriated at this last humiliation.

At this moment he happened to look at the screen. The picture was a murder mystery called The Mad Doctor of Market Street. It will be noted that on admission to the hospital he remembered that he had 'fallen asleep' while watching a picture about murder. At the moment that he glanced at the screen, the 'mad doctor' was in the act of stabbing a sailor with whom he was struggling in the water for possession of a lifeboat. The murderous eyes of the mad doctor were shown in a close-up, and at this instant the patient 'fell asleep'. It was possible to establish that he had not fallen asleep but was in a hysterical stupor. This stupor was actually the onset of his fugue. In this state the patient kept muttering to himself over and over, 'He's not going to make a fool of me. I'll get him when we get outside.' When he saw the mad doctor stab the sailor he was seized with an impulse to stab X, and then he 'fell asleep'. Under hypnosis while he was reliving the fantasies which took place during this stupor, it was noted that he happened to have a pencil in his hand with which he

kept making stabbing motions in the air. Immediately upon awakening from this trance he stared at the pencil and remarked that he thought it was a knife and he had an impulse to stab some one.

When he awoke from his 'sleep' an hour or more later he was walking out of the movie, still with the thought uppermost in mind of 'getting X'. When he entered the bar he saw a civilian and felt that this individual was X and also a doctor. This man was staring at him with the same peculiar look in his eyes as had the mad doctor in the movie; he looked right through him as if he could tell what the patient wanted to do. The patient became fearful that this man would 'get him first'. It was evident that the civilian was a hallucinatory figure, a fusion of X and the mad doctor, upon whom the patient had projected his own murderous impulses toward X. The patient continued to hallucinate this figure and felt that he was being followed down the street. Then when the shore police asked his name, he became aware for the first time that he did not know who he was.

During his last hypnotic session the patient was brought back to the moment when he was talking to the shore police, and it was suggested to him that at that time things going on in the back of his mind had made him forget his name, and now he would remember them. With much emotion and real terror he began to whisper, 'Knife, knife, knife. I want a knife. He has a knife. I have nothing. He's white and I'm colored; I'll get it if I kill him,' etc. At one point, significantly, he remarked, 'I want a knife, not a name'. It appeared that he was obsessed with the thought of the knife and that this had something to do with his inability to remember his identity.

The patient's encounter with X had a background. While they were stationed together in the South a negro had been lynched for the alleged rape of a white woman. X had taken the occasion to remark to the patient that all 'niggers' deserved the same fate and that 'the only good nigger is a dead nigger'. Thus the patient was indulging in some very dangerous fantasies when he played with the idea of taking X's girl away

from him. This factor may well have added to the guilt and terror he experienced when he was seized with the impulse to murder X.

Since this patient attained excellent insight into the psychogenesis of his fugue he was returned to duty. However, he returned to the hospital several weeks later because he had developed a series of brief 'lapses' of memory. He would become deeply absorbed in his thoughts for a few moments, and would not, for example, hear his name when addressed. One of these lapses lasted for about an hour. These episodes did not appear to be etiologically related to the major fugue just discussed.

2. *Fugue with Change of Personal Identity*

Under this category are included those patients who during the course of the fugue or at its onset assume a false name, that is, undergo a change in personal identity. Two possible explanations suggest themselves: either the patient realizes that he has lost his identity and knowingly assumes a false name, or from the very onset of the fugue he may unconsciously identify himself with the person whose name he takes. In the latter instance the assumption of the false name might be associated very intimately with the unconscious fantasies responsible for the genesis of the fugue state. None of our patients assumed a false name knowingly. The two cases to be presented here illustrate the second possibility.

Case Three: GH, a forty-four-year-old petty officer in the U. S. Coast Guard, presented a very complex picture and unfortunately left the hospital before all the ramifications of his illness could be traced. Although at the time of admission he was in a state of awareness of loss of personal identity, it was discovered subsequently that he had had at least three major fugue states and many minor ones, extending back over a period of eighteen years. In several of these he traveled under an assumed name.

On admission the patient was moderately intoxicated, seemed quite depressed and somewhat confused, but could speak rationally. He complained that he was being chased by three men, that he saw them wherever he went. He believed they wanted to kill him and

he heard them call him obscene names. He did not know his name but thought it might be 'Sammy'. He knew nothing about his past life but had some fragmentary memories about being in several other hospitals. He believed he was in the navy. He did not know what he looked like and could not state the color of his hair or eyes; indeed, he mistakenly believed that his hair was not gray. He believed he was thirty-seven years old and that it was 1937. His hallucinations, both visual and auditory, concerned only the three men who were his supposed pursuers. He could not perform simple calculations. He did not know whether he was married or single or anything about his family.

At first this patient presented a difficult problem in differential diagnosis. He appeared to have an amnesia of the awareness of loss of personal identity type. Yet his active hallucination suggested a paranoid psychosis, and his drinking, though it was not very heavy, suggested alcoholic hallucinosis. In spite of his hallucinations and disorientation he did not give the impression of an ordinary paranoid psychosis. He was greatly perplexed by the loss of his memory and personal identity and made strenuous efforts to remember. After several hours of persistent effort and with much coaxing on my part, his memory gradually returned. He first recalled the names of his wife and children, then his own, and finally remembered his entire past. This occurred without hypnosis. Just as soon as his memory was restored his hallucinations disappeared. Prior to this he would glance up at every noise and fancy he saw his pursuers. With the return of his memory he became oriented, lost his confusion, regained his ability to perform calculations, and recovered all his general knowledge and information.

It was then found, as noted, that he had previously had a number of fugue states each of which was represented by a gap in his memory. Under hypnosis these fugues were partially reconstructed. Although the first one had occurred some eighteen years before and had lasted about six weeks, during which he had traveled from New Hampshire to Texas, the memories of his experiences returned to him in a series of

kaleidoscopic pictures and were as vivid as though of very recent origin. During the three major fugues preceding the one which resulted in his hospitalization he had traveled under the name of a favorite uncle. The psychological meaning of this change of identity was not worked out but it was discovered that the patient identified himself with this uncle who was a failure in life. He felt that they were both the black sheep of the family.

The fugue which brought the patient to the hospital had been in existence a long while, at least several months, and was complicated by several intercurrent remissions. The entire illness had a decidedly psychotic coloring. In this last fugue he was in constant terror because of his fear of being followed, but he stated that in the others he felt happy and unworried. He did not know who he was or where he was going or anything about his past. It never occurred to him that he did not know these things; he just kept going.

Case Four: In this case the psychological meaning of change of personal identity is considerably clearer. This is not one of the author's cases, but one which has been beautifully worked out and reported by Geleerd, Hacker and Rapaport *(5a)*.

The patient, IJ, was a housewife, twenty-six years old, who had had several episodes which were called 'twilight states', during the three month period prior to her hospitalization. All of these were connected with the sexual approaches of men and lasted only a few minutes. The fugue which brought her to the hospital occurred under the following circumstances: the patient and her husband spent an evening at a party. Some of the men there paid a lot of attention to her and she wanted to stay on. Her husband, however, took her away. She went with him reluctantly to a hotel. She asked if she could leave. He said, 'You may go now'. At this moment she entered the fugue state. Under sodium amytal narcosis it was found that the above remark was taken by the patient as an order. She thought he meant to say, 'Go and be a good girl' or 'Go along and be a bad girl; enjoy yourself'. Accordingly, she left and went to the lobby of the hotel. As she entered a man snapped his fingers. She took this as a command and went with him to his room, spent the night with him, having intercourse

several times. The stranger thought she was a prostitute and frequently asked her if she went with men professionally. On the telephone he boasted to his friends that he had 'picked up a nice number'. She identified herself as Nancy, which was the name of a girl friend in whose husband the patient was sexually interested. The stranger was puzzled because she spoke about the weather constantly. She explained this by stating, 'My husband, who usually did all the thinking for me, once said: "If anybody picks you up, talk about the weather" '. The patient stated that the command, 'You can go now', was like hitting her on the head, and that at that moment she turned into a streetwalker and identified herself with Nancy. The point that should be stressed here is that she *was* Nancy. On awakening in the morning she noticed that she was in a strange environment and had no memory for what had happened to her since leaving her husband.

3. *Fugue with Retrograde Amnesia*

Under this heading will be presented two cases of fugue, in which there was neither awareness of loss of personal identity nor change of identity, but a reversion to an earlier period in the patient's life with retrograde amnesia for events subsequent to that period. Allusion to this type of fugue has been made by Rapaport *(5)*.

Case Five: The patient, KL, was a twenty-three-year-old white coastguardman, who was found one day in an apparently unconscious condition in the shower room of his barracks. He was taken to a hospital where he remained stuporous for two days. When first seen by the author about a month later, he had an amnestic gap covering this two day period. He remembered only that on a certain Monday he was in the mess hall; shortly thereafter he must have made a telephone call, since he vaguely remembered walking out of a phone booth but had no idea whom he could have called. While he was in the mess hall he suddenly dropped the food tray he was holding; the next thing he knew he came to in the hospital two days later.

Under hypnosis the following story was reconstructed: at the moment he dropped the food tray, which marked the onset of the fugue, he was thinking about what had happened the

previous day. He and a friend had gone to visit the latter's girl and she had prepared dinner for them. He was thinking about how bad the service food was and wishing he had a good meal such as he had had the day before. He immediately went to the phone, called up the girl and thanked her for the dinner of the previous day. While relating this incident, the patient showed obvious guilt over making the telephone call. He protested over and over how much he loved and missed his wife and insisted that he was not interested in any other girl. Nevertheless, he was greatly concerned that his wife might find out about his making the call. He made derogatory remarks about the girl, protested that his wife was much prettier, etc. It became obvious that behind his expressions of gratitude to the girl for the dinner there lay repressed sexual wishes concerning her. At a deeper level, material was obtained which strongly suggested that the patient harbored incestuous wishes towards his mother and sister which had a strong oral coloring and may have determined the 'oral' approach toward the girl. It may be noted that the patient married at fifteen and had been faithful to his wife for eight years. He was now far away from home and subject to many sexual temptations. Behind the protests of his great love for his wife there was a strong wish to leave her.[1]

[1] In working out the dynamics of fugues and in overcoming resistance, it has been found very helpful to utilize experimentally induced dreams under hypnosis, as described by Farber and Fisher *(9)*. For example, in the case under discussion the patient had great resistance to recognizing that he might be erotically interested in a girl other than his wife. Under hypnosis he was made to live through in fantasy his actual situation, namely, in the service, far from home, celibate, subject to many sexual temptations, and then told that a dream would come to him. He then had a dream in which he made overt sexual advances to a girl. On awakening from the trance he remembered the dream and thereafter it became easier for him to accept the possibility that he might have extramarital sexual wishes. He also gained some insight into the possibility that such superego-alien wishes might have some causal relation to his fugue. With another patient who showed great resistance to recalling the events of his fugue, it was simply suggested under hypnosis that he would have a dream. In this dream he expressed the conflict which precipitated his fugue, and thereafter he was able to remember what had transpired during the fugue. By means of a posthypnotic nocturnal dream a third patient remembered a fugue the very existence of which had escaped his conscious memory.

Following the telephone conversation he took a shower, suddenly became dizzy and fell into a stupor. He was found unconscious and when aroused insisted that he was not in New York but back in his home in Georgia, apparently in an earlier period of his life before he had joined the service. It is this retrograde amnesia which is of special interest in this case. It is to be noted that the patient fell into a stupor in the midst of his fugue and that he remained stuporous or semi-stuporous for two days.

Case Six: This case illustrates, in an even more clear-cut fashion, a fugue in which there was a retrograde amnesia with disorientation for time and place. At the same time there was a retention of personal identity and memory of the past, aside from the period covered by the retrograde amnesia.

The patient, MN, was an eighteen-year-old white merchant seaman who was admitted to the hospital with a history of having suffered a loss of memory on the preceding day for a period of about ten hours. He had obtained liberty from his ship late in the afternoon and was to be back by midnight since the ship was about to sail for Murmansk. He 'blacked out' on the bus going into the city and 'came to' early the next morning in a naval hospital.

Under hypnosis it was found that he had a great fear of making the Murmansk run, having heard many terrible stories of its dangers. The fugue enabled him to miss his ship. After he 'blacked out' on the bus, he proceeded to New York and soon found himself in a park. Suddenly he became puzzled about his surroundings and discovered that he was in a strange city, whereas he had thought he was in Newport, Rhode Island. He bought a newspaper and was aghast to find it was July 1944, because he had thought it was December 7, 1942. He approached a police car and asked to be taken to a naval hospital. The report from this hospital is of interest because the patient was seen there while still in his fugue, an unusual circumstance. By the time he was first interviewed by the

author he had recovered. This report states that the patient was unable to remember anything since December 7, 1942, but that he spoke coherently. He believed himself to be an apprentice seaman in the navy though his papers indicated that he was a merchant seaman. He had no memory of his merchant marine experiences. However, he knew his name and the events of his past life up to December 7, 1942. It was found that the patient had actually been in the navy on that date and was stationed at Newport. Curiously enough, on that date he had had a brief fugue as a consequence of which he received a medical discharge from the navy. Why there was a continuity of memory between the two fugues was never ascertained. The significant finding in this case is that the retrograde amnesia covered the period of the patient's merchant marine experience although the memory of his past life was otherwise intact and there was no loss of personal identity.

DISCUSSION

The available material supports the conclusion that the state of 'awareness of loss of personal identity' is preceded by a fugue. However, not every fugue terminates in this state, even in the same patient. Three of the author's patients had three or more fugues, only some of which ended in the state of 'awareness of loss of personal identity'. The state may develop in different patients in different ways. Patient AB, for example, only became aware of his loss of identity when somebody happened to ask him his name. During the thirty days of his wanderings through the African desert nobody asked his name and his identity never became a problem to him—it simply never occurred to him. In other patients there is a 'spontaneous' recognition of loss of identity. In these cases the patient asks himself his name; or his surroundings or circumstances pose the question.

Since Janet *(10)* it has been known that fugues are related to somnambulism and through the latter to dreams. The fugue is like a somnambulistic episode which occurs in the daytime,

and the somnambulistic episode is a dream which finds motor expression. The author agrees with Geleerd, Hacker and Rapaport *(5a)* that the individual in a fugue is really a dreamer walking and acting out his dream. As in the dream, so in the fugue there appear to be manifest and latent 'contents'. In the fugue the manifest content appears to be acted out; at least the latent unconscious wish or wishes do not in many cases obtain expression. For example, patient AB while sitting in the movie was overwhelmed with anxiety when he saw a soldier being stabbed by a Nazi. He went into a fugue and became dominated by the idea that he had to get to the Canadian border to join the army. This idea covered up the 'latent content' of the fugue which was, 'I am frightened; I have to get away. If I get to Canada and join the army a Nazi may bayonet me.' He set off on his travels dominated by the intention of getting to the Canadian border but was simultaneously propelled by the 'latent fugue content' in precisely the opposite direction, away from the Canadian border. The process of distortion is even clearer in the case of patient CD. This patient was possessed by the idea of being followed by a man who was going to kill him with a knife. Behind this manifest content was concealed his own unconscious wish to murder the sailor, X. He projected his wish on to the man in the bar who in an hallucinatory fashion became the fused image of the sailor and the 'mad doctor'. This type of fusion figure frequently occurs in dreams. Some fugues, at any rate, have to be interpreted in the same manner as one interprets dreams. In both the instances mentioned, a forbidden wish found expression but in a disguised form.

The analogy of the fugue with the dream has been expressed by Rapaport *(5)* in a different fashion. He supports the theory that memory organization is determined by strivings, affects and attitudes, and suggests that so-called 'dissociated' memories are organized around a striving, a striving that condenses and expresses symbolically a set of unacceptable strivings. This process occurs in fugues. The single striving (to get to Canada, running away from the sailor-mad doctor) is carried out only

if at the same time the 'implicit forbidden strivings' are kept under repression. This striving 'becomes so powerful that it gains control of the motor and perception systems as well as of the memory and thought processes'. In the above discussion the 'single striving' represents what we have called the 'manifest fugue content' and the 'unacceptable strivings' the 'latent fugue content'.

A complete explanation of the nature and meaning of the state of awareness of loss of personal identity is not yet forthcoming. However, certain tentative formulations may be made. It will be recalled that Rapaport *(5)* distinguished between 'loss of personal identity' and 'awareness of loss of personal identity'. This distinction needs further clarification, for it seems to involve a logical inconsistency. It is not possible to have a loss of personal identity without awareness of that loss. A person in the waking state engaged in some kind of activity is not aware of his name; he is aware only of the objects of his perception, physical and mental. He does not become aware of himself (as a person who has a name and a past history) unless he reflects upon himself, i.e., makes himself an object of perception *(11)*. Patient AB remarked that in several of his fugues the problem of his identity never occurred to him. Therefore, in this instance one cannot speak of 'loss of personal identity', although there may have been present the potentiality for experiencing the state of 'awareness of loss of personal identity' if circumstances had been such as to cause him to reflect upon himself. The only evidence available that there may be such potentiality is the remark of patient AB, made after the event, that if he had been asked his name in several of his fugues he is certain that he would not have been able to give it.

If during the fugue the patient is suddenly confronted with the question, 'What is your name?' he is forced to reflect upon himself, that is, to identify himself (as one always does) by his name and his past history. In a certain sense a person is what he has done and experienced. But in the fugue the individual is always doing something which is in conflict with his superego;

he is not only running away from a danger, but from himself as well. The question about the name, then, may be interpreted unconsciously as an accusation and may come to mean, 'What have you done?'. This is true whether the person asks himself his name, or the question comes from an external source. It is possible, therefore, that the patient protects his ego by concealing it, by forgetting his name and his past history *(11)*. In this connection it is interesting to observe how many patients who experience loss of personal identity behave like hunted criminals and how frequently they manage to turn themselves over to the police or fancy they are being hunted by the authorities. Patient AB avoided the military authorities in the African desert for weeks. Both patients CD and GH felt they were being followed and hallucinated their persecutors. Patient CD sought out a shore patrol and while being questioned stated that he had been AWOL for one hundred and four days, a confession which was completely false. It was as though he felt compelled to confess to a minor crime in order to cover up the fantasied major crime of murder. By denying his identity he also denied the crime which he had committed in fantasy. Indeed this patient, while reliving under hypnosis the period when he became aware of his loss of identity, said, 'I don't want a name, I want a knife'. It should be noted that not only are we concerned here with fantasied acts, but also with real antisocial acts, such as deserting a ship or one's unit at the front.

It is therefore suggested that in the fugue the patient indulges in acts or fantasies which are in conflict with his superego and the function of the fugue is to permit the carrying out of these acts or fantasies. During the course of the fugue additional defense mechanisms are set into motion depending upon the type of fugue which develops. In the 'awareness of loss of personal identity' type, the subject attempts to deceive his superego by concealing his ego, that is, by losing his identity. It is as if the patient says, 'I did not commit this crime because I am not I; I am nobody; I have no name and no past'. In the second type considered—fugue with change of personal

identity—a different psychological formula is brought into play. It is as if the patient says, 'I did not commit this crime, because I am not I; I am somebody else'. This is what occurred in the case of the girl with the prostitution fantasy who became 'Nancy' during her fugue. In the third type of fugue a less drastic distortion of memory takes place. The patient does not lose his sense of personal identity and only a part of his memory of the past disappears. In this instance it is as if the patient says, 'I did not commit this crime, because the crime was never committed; these events never occurred. On July 15, 1944, I did not desert my ship, because July 15, 1944, never happened; this is December 7, 1942.' This is the type of memory distortion of the patient MN, who deleted from his memory the period of time covered by his merchant marine experience and believed himself back in the navy. It is very probable that many so-called retrograde amnesias reported in the literature are really fugues in which this third type of memory distortion occurs. It is therefore suggested that each of the types of fugues discussed is a special type of defense mechanism.

It is also to be noted that other types of defense mechanism are brought into play during the course of the fugue and help to determine the form which it takes. In some fugues a simple type of rationalization occurs, as for example when the patient believed he called up a girl to thank her for a dinner, where in fantasy he was having sexual thoughts about her. In other cases the mechanism of projection is brought into play as a defense against the superego alien impulse—as in patient CD—and this may ultimately lead to the formation of delusions and hallucinations. In the change of personal identity type of fugue it is clear that the mechanism of identification is utilized; the patient *was* Nancy during the period of her fugue.

Every crime has its time, place and person, and in the types of fugue discussed, either two or all three of these elements are abrogated in the patient's mind in an attempt at concealment of the acts or fantasies alien to the superego. In the first two types discussed it is as if the patient removes himself

from the scene of the crime, while in the third he buries the body.

It has been noted that patient GH had a loss of memory of his body image: he could not describe his face or give the color of his eyes or hair. While in this state he was confronted with a mirror and there is no doubt that he seemed strange to himself. However, as he looked his face seemed to become familiar to him. He finally pointed to a mole and guessed it was his face because he remembered this blemish. Patient CD was also confronted with a mirror and likewise gave the impression that he was estranged from his physical image. Further and more detailed observations of this kind need to be made. It would seem that the loss of memory of body image is intimately related to loss of personal identity and memory of the past. These observations raise problems with reference to the development of the ego in relation to the sense of personal identity and the genesis of the body image.

If the memory of the past is forgotten it could be assumed a priori that memory of the body image would also be disturbed. Schilder *(12)* has suggested that we do not perceive our bodies differently from objects in the outside world and denies Freud's contention that for the newborn child only the body exists and not the outside world. He stated, 'Body and world are experiences which are correlated with each other'. If one has forgotten his past experiences it is to be expected that he would also forget his body image, i.e., his memories of his experiences related to his body. Body image and names—especially nicknames—frequently have important affective associations. People are called 'Fatty', 'Skinny', 'Red', 'Tiny', or other names which are directly connected with their body appearance. Or it may be said of a person that he is a 'Smith' or a 'Brown', depending upon whether he resembles in physical appearance the paternal or maternal side of the family.

The psychological significance and meaning of names needs further study. An infant as young as six months will respond to its name. One's name is the medium through which one is able to objectify oneself, to take the attitude of the other

towards oneself, to treat oneself as an object. The name is a very important segment of the ego. It is a kind of monogram for the sum total of a person's memories, or perhaps it would be more correct to say, for the sum total of memories of *affective* significance. For it is clear that in the state of awareness of loss of personal identity, the ego structure is by no means totally disintegrated. Ego and personal identity are not synonymous; the 'I' is more extensive than the name. These individuals know what a name is; they know that they ought to have one and are frequently puzzled that they cannot remember it. They know they have a past history and they make strenuous efforts to recapture it. They therefore retain the language function and general knowledge pertaining to abstract, non-affective matters. It may be noted, however, that even these functions may be interfered with, as in the case of patient GH who lost the ability to do simple calculations or even to count correctly.

The fugue appears to develop in the following fashion: there is always a preparatory phase during which anxiety of ever-increasing strength is developed. The individual who develops a fugue is always in the situation described by Herold *(13)* in which he can neither escape from an anticipated and imagined danger nor fight against it. He therefore makes a subjective escape from consciousness and thus the fugue must be included among the conditions designated as 'escape from consciousness'. He is unable to fight because he is afraid and he cannot escape because of the demands of conscience that he do his duty. This is the predicament in which patient AB found himself and which is generally present in most war neuroses. Prior to the onset of the fugue the patient represses both his fear and his desire to escape. As Herold has noted, 'The individual who represses escapes from consciousness of danger. He represses the inner wishes which threaten him, or he represses the representation of external danger itself. He cannot therefore any longer be described as having fear. The resultant state is one of anxiety which is a reaction to the danger which has become unconscious and to which the indi-

vidual therefore cannot react by trying to escape or to fight. Anxiety is therefore a state of mind best described as a suspense reaction to an unconscious danger.' It is astonishing how deep and effective repression can be in individuals prone to fugues. They are so effective that while the patient is unconsciously in a state bordering on panic at the thought of returning to combat, consciously he may feel that the one and only thing he wishes to do is to return to duty and he may make requests to be permitted to do so.

As anxiety increases the mechanism of repression breaks down and there is a return of the repressed, that is, the fear and the wish to escape threaten to break into awareness. Usually the breakdown is precipitated by some external stimulus, such as the picture of the Nazi bayoneting a soldier in the case of patient AB, or the sight of the 'mad doctor' with the knife in the case of patient CD. The psychological process which occurs when the repressed affects threaten to break into awareness is not entirely clear. It is at this point that the concept of dissociation is usually brought in to explain the subsequent course of events. It would perhaps be best to abandon this obscure term and stick to description. All that is certain is that the patient enters a dreamlike state in which fantasy predominates over reality and reality testing is abandoned in favor of autistic thinking, even to the point of the development of hallucinations. The repressed affects find release in the dreamlike state of the fugue in the form of the manifest fugue content which is expressed in action. With this the patient breaks the deadlock between his fear and his wish to escape. He does in effect escape but only by deceiving himself into believing that he is doing something else, e.g., running toward the Canadian border when he is actually running away from it.

Janet *(10)* was of the opinion that hallucinations do not occur in fugues, although it is evident that they did develop during the fugues of patients CD and GH. He would have called these states hallucinating somnambulisms. However, they appear to partake more of the nature of fugues. In the midst of their

hallucinations both of these patients were made aware of their loss of personal identity. In patient CD this awareness brought about a termination of the hallucinations, although he continued to experience periodically a vivid mental picture of the eyes of the 'mad doctor'. Patient GH continued to hallucinate while at the same time he became greatly preoccupied with his loss of memory. Rapaport *(5)* reports a case of fugue with awareness of loss of personal identity which was followed by a period of intense hallucinatory activity.

The presence of hallucinations in these fugues also tends to ally them with somnambulism and dreams. The dreamlike nature of the fugue and its close relation to sleep is further indicated by the fact that very frequently in the fugue there is a preliminary period of clouding of consciousness: the patient reports that he felt dizzy, had a headache or was very tired. Furthermore, the initial stage of the fugue may take place in a sleeplike stupor which is rich in fantasy production. As noted, several of the patients reported that they 'fell asleep' at the onset of the fugue or had periods of 'sleep' during the course of the fugue. The remark of patient AB that being in a fugue was like being hypnotized is also of interest here.

The rôle which anxiety plays in the genesis of the fugue has been noted. The presence of anxiety also helps to explain the break with reality which permits the proliferation of fantasy and the development of hallucinations. Herold has remarked that 'pain makes us body conscious' and causes the body to become more and more like an external object which preoccupies the senses and thus displaces the external world from sensual perception. On an emotional level psychic pain or anxiety results in a similar displacement with reference to the ego. 'Anxiety is the emotion which prevents us from using our senses to experience external objects. It is the center of a vicious cycle which leads to an increasing alienation from reality' *(13)*. Anxiety brings about a replacement within the ego of reality by fantasy.

The degree of anxiety present in the fugue must determine the severity of the alienation from reality. It may also have

some connection with the fact that certain patients in the fugue spontaneously become aware of their loss of identity, while others do not attain awareness until it is forced on them by external circumstances. The two patients who hallucinated and were well-nigh in a panic were totally unaware of the problem of their identity until asked their names. Patient EF, during one of his fugues, was calm enough to notice that his surroundings were unfamiliar and that he had on a uniform which he did not recognize. From here he went on to inquire of himself who he was; he then became aware spontaneously that he did not know his name or his past history.

In fugues in which hallucinations occur, the alienation from reality may be extensive enough to give these states the appearance of psychosis. Both patients CD and GH developed hallucinations with the delusion that they were being followed and that their persecutors wanted to kill them. In spite of these clearly paranoid ideas, neither patient gave the impression of being psychotic. The element which differentiates these states from psychosis is the disappearance of the hallucinations and delusions as soon as memory of personal identity is restored. Stengel *(14)* is of the opinion that fugues with 'impulse to wander' are produced by a coincidence of neurotic and psychotic mechanisms and suggests that they are related to the manic-depressive syndrome. He also considered these states symbolic suicidal acts. Abeles and Schilder *(6)* likewise suggested that loss of personal identity is a form of psychologic suicide, an 'attempt to escape from punishment and at the same time a self-punishment by effacing one's personality'. It has been suggested above that the loss of personal identity is an attempt on the part of the individual to protect his ego by concealing it, and is, therefore, just the opposite of a symbolic suicide. It seems probable that fugues can no longer be considered as simple hysterical conversions; they would appear to represent a more serious type of disorder. Geleerd *et al. (5a)* are likewise of the opinion that fugues stand somewhere between neurosis and psychosis.

Geleerd *et al.* have presented the very interesting hypothesis

that in fugues superego function is paralyzed and eliminated and the fantasy breaks through. They suggest that the fantasy when seizing consciousness becomes its exclusive content and in turn now represses everything which had previously been conscious content, including the sense of personal identity. They state, 'It seems that in some cases at least (and possibly in all) the fugue state is brought about by a reversal of the process by which the superego was originally created. The superego or parts of it seem to be placed again into the outside world and some outside authority takes on the functions of the superego for the duration of the amnesia.' The author agrees that in some sense the superego function in the fugue is weakened; otherwise the alien fantasy could not break through into consciousness and overt activity. However, it does not seem that its function is by any means entirely eliminated. It has been the object of this paper to show that the various types of memory distortion present in fugues are defensive mechanisms which are brought into play at the behest of the superego. It is because of this persisting superego activity that the individual is able to defend himself against alien impulses by losing his identity, changing it or having a retrograde amnesia. It does not seem to the author that fugues are explicable in terms of the usual concepts of ego and superego; that ultimately other operational principles will have to be utilized when we know more about fugues.

The value of the use of experimental dreams in the reconstruction of fugues and for the purpose of by-passing resistances has been mentioned. Another technique which has proved to be of value in a number of instances is the following: under hypnosis the patient's essential conflict is described to him and he is told that during the night 'matters will rearrange themselves' in his mind, so that in the morning everything will be clear and acceptable to him. The idea for this procedure developed from the discussion of unconscious mental activity in hypnosis by Erickson and Hill *(15)*. The purpose of this technique is to weaken the demands of the superego. In discussing the relationship between hypnotist and subject, Kubie

and Margolin *(16)* have suggested that the image of the hypnotist 'functions in the subject as does the residue of parental images in adults. It delimits memories and contacts, dictates purposes, distributes inner rewards and inner punishments, and engenders strong affects. In some measure, therefore, it temporarily dispossesses the earlier authorities (i.e., the superego), or merges with them.'

In conclusion, it is not to be supposed that all fugues follow the psychological patterns described in this paper; other possibilities exist. The entire problem of fugues requires further investigation. One of the small contributions of World War II, unfortunately, is the wealth of material that will be furnished for this purpose.

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'REPRESSION' IN PREFREUDIAN AMERICAN PSYCHIATRY

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The word 'repression' is inevitably and indissolubly linked with the name of Freud. It could hardly be otherwise, indeed, since the concept of repression is in the first place, as Freud himself denoted it, the foundation stone on which the whole structure of psychoanalysis rests, 'the most essential part of it'.[1] For it was Freud who, following a lead of Bernheim, first asserted that certain (pathogenic) memories 'were in the possession of the patient, ready to emerge and form associations with his other mental content, but hindered from doing so, hindered from becoming conscious and compelled to remain in the unconscious, by some sort of a force. . . . These same forces, which, as resistances, opposed the emergence of the forgotten ideas into consciousness, must themselves have in the first place caused the forgetting, and repressed from consciousness the pathogenic experiences. I called this hypothetical process "repression" ', Freud continues, 'and considered that it was proved by the undeniable existence of resistance'.[2] Thus it was that, on the basis of a type of clinical observation which he was the first to make, Freud arrived at a conception—namely, that of repression —which he thought of, quite naturally, as having come to him independently of any other source, one that he supposed to be entirely his own [1], a doctrine which was the outcome of psychoanalytic work and which could not have been formulated before the time of psychoanalytic research.[3]

Like other scientific pioneers, however, Freud had his precursors. Among these, and in respect of this very concept of repression which with good reason Freud had considered pecu-

[1] Freud: *On the History of the Psychoanalytic Movement.* Coll. Papers, I, p. 287.

[2] Freud: *On Psychoanalysis.* Amer. J. Psychol., 1910.

[3] Freud: *Repression.* Coll. Papers, IV, p. 84.

liarly his own, was Schopenhauer. That philosopher, as Otto Rank later pointed out [4], spoke very specifically, in The World as Will and Idea (1818), of the struggle against the acceptance of a painful part of reality, in a way which completely fitted Freud's conception of repression; what he said—and in so doing he formulated for the first time (according to Rank) the idea connoted by the term 'repression'—was that 'certain events or circumstances become for the intellect completely suppressed, because the will cannot endure the sight of them'.[5]

So much for Schopenhauer's (intuitive) recognition of the mental mechanism which three-quarters of a century later

[4] Rank, Otto: *Schopenhauer über den Wahnsinn.* Zentralbl. f. Psa., I, 1910, p. 69.

[5] The passage is certainly worth quoting in full; it runs as follows: 'The exposition of the origin of madness . . . will become more comprehensible if it is remembered how unwillingly we think of things which powerfully injure our interests, wound our pride, or interfere with our wishes; with what difficulty do we determine to lay such things before our own intellect for careful and serious investigation; how easily, on the other hand, we unconsciously break away or sneak off from them again; how, on the contrary, agreeable events come into our minds of their own accord. . . . In that resistance of the will to allowing what is contrary to it to come under the examination of the intellect lies the place at which madness can break in upon the mind. Each new adverse event must be assimilated by the intellect, *i.e.*, it must receive a place in the system of the truths connected with our will and its interests, whatever it may have to displace that is more satisfactory. Whenever this has taken place, it already pains us much less; but this operation itself is often very painful, and also, in general, only takes place slowly and with resistance. However, the health of the mind can only continue so long as this is in each case properly carried out. If, on the contrary, in some particular case, the resistance and struggles of the will against the apprehension of some knowledge reaches such a degree that that operation is not performed in its integrity, then certain events or circumstances become for the intellect completely suppressed, because the will cannot endure the sight of them, and then, for the sake of the necessary connection, the gaps that thus arise are filled up at pleasure; thus madness appears. For the intellect has given up its nature to please the will: the man now imagines what does not exist. Yet the madness which has thus arisen is now the Lethe of unendurable suffering; it was the last remedy of harassed nature, *i.e.*, of the will'. (*The World as Will and Idea*, 3rd ed., Vol. III, pp. 168–9; trans. Haldane.)

Well has Freud said that he is prepared—and gladly so—to forego all claim to priority in the many instances in which laborious psychoanalytic investigation can merely confirm the truths which the philosopher—and the poet—has recognized intuitively.

Freud postulated on the basis of clinical observation and called 'repression'—the psychical process which he first elucidated and illustrated clinically in the *Studien über Hysterie* of 1895. Of this formulation of Schopenhauer's, Freud quite pertinently remarks that 'others have read the passage and passed it by without making this discovery'.[1]

Freud himself, in turn, with reference to the defensive striving against painful memories which is the essence of repression, drew attention to the fact that no one had so well described both that process itself and its psychological basis as had Nietzsche in saying (in Beyond Good and Evil): 'I have done that, says my memory. I cannot have done that, says my pride, and remains inexorable. Finally—memory yields.'

We come now to an American psychiatrist who, writing in the year before Freud first set pen (psychoanalytically) to paper, and three years prior to the *Studien über Hysterie,* not only used the word 'repression' [6] but wrote of the phenomenon which he so termed, and which was manifested, as he conceived, by the patient whose case he was describing, as if it were a term and a phenomenon the existence of which any psychiatrist would take for granted. I refer to Charles W. Page, then Superintendent of the Danvers Lunatic Hospital in Massachusetts, who in 1892 published a paper entitled, The Adverse Consequences of Repression.[7] This paper was the first contribution to American psychiatric literature, to my knowledge, to take cognizance of what its author termed 'repressed emotional sentiments'.[8]

Dr. Page tells us, in the first place, that the distressing circumstances attending an impressive case awakened in him, in the

[6] A word not to be found in Hack Tuke's *A Dictionary of Psychological Medicine,* published in the same year (1892), and therefore, presumably, not a part of the psychiatric vocabulary of that date.

[7] Amer. J. Insanity, XLIX, 1892–93, p. 373.

[8] Dr. Charles Whitney Page, born in 1845, graduated from the Harvard Medical School in 1870, being thus a classmate of James Jackson Putnam. He was Superintendent of the Danvers State Hospital from 1888 to 1898, and from 1903 to 1910. (E. E. Southard: *The Laboratory Work of the Danvers State Hospital, Hathorne, Mass., With Special Relation to the Policy Formulated by Dr. C. W. Page.* Boston Med. and Surg. Jour., CLXIII, 1910, p. 150.)

early days of his hospital experience, 'a deep and lasting interest in the subject of repression and its adverse consequences'. The case in question was that of a charming young lady who had become violently insane—a girl who, carefully reared by cultured and wealthy parents of excellent social position, had been conscientious in her religious devotions, had maintained a spotless character, and was regarded by all who knew her, we are told, as an example of angelic purity and Christian womanhood. On the other hand, her normal power of endurance, we are also told, had been overtaxed at school by 'ambitious efforts to excel, self-imposed exactions in the line of duty, and vague but persistent dread of ultimate failure'. This background threw into sharper and more shocking relief her presenting psychotic symptom, which was the utterance of a constant stream of 'coarse, profane and vulgar language'.

It so happened that this patient's own physician, although a man who had made the study and treatment of insanity his life work, was so nonplussed by this outbreak of lewd and profane language, so opposite in every respect to all that was known concerning the young woman's life and character, that he felt constrained to refer this manifestation to supernatural origin. This circumstance gives Dr. Page the opportunity not only to animadvert, even as late as 1892, upon the theory of demoniacal possession as an explanation of mental derangement, but to state that 'the assumption that the vocal organs of this patient responded to impulses issuing from some source other than the ideo-motor regions of her own brain . . . is unworthy of serious consideration'. On the contrary, he adds, 'she must have given expression, in her ravings and mutterings, to ideas and language which represented, in some sense, her mental endowment'. For, however startling and novel the ideas which may be given utterance, 'still the lunatic can use only what he can lay hold of in his own mind; what the insane man expresses, and the dreamer fabricates in his own thought, are but reflections from a background of previous mentality'. However naively these statements may seem to us to be couched, they imply an insight which was not universally prevalent in

the year 1892. For what Dr. Page here appears quite obviously to grope towards is the idea that the 'lewd and profane' language of this patient, since it certainly expressed in some sense her mental endowment, represented the escape from repression of the sexuality with which the high moral and intellectual development of her ego had brought her into conflict, and which had accordingly undergone (a now no longer successful) repression.

Dr. Page further believed that 'auditory hallucinations are exceedingly liable to voice ideas and suggestions which the subject of them has endeavored to rule out of his mind and life, or which he has contemplated only with fear and trembling, thus linking them the more closely to his personality and rendering them the most aggressive thoughts in his mind'. Dr. Page clearly seems to be here describing, in other language, a repression which has proved unsuccessful, the fear felt by the ego of these impulses which in defense it has attempted to repress, and the capacity of the latter to overwhelm the former through their 'aggressive' character (which Dr. Page seems to attribute, here and elsewhere, precisely to the fact of their having been repressed—'ruled out of the patient's mind and life'). In much the same vein, and perhaps even more pertinently, runs Dr. Page's further comment upon the patient: 'In her normal mental condition, her rational faculties, the exercise of attention and will, had served to keep the knowledge of such things [as she expressed in her lewd and profane language] effectually concealed from her most intimate friends; but the intense egotism which accompanies mania, heedless of criticism, objection or consequences, had ruthlessly torn aside the thin veil of silence, hitherto so serviceable. The ban of secrecy concerning her inmost thoughts was forgotten when paralysis of the higher mental powers supervened, and the warning sign, "Not to be spoken", with which each forbidden word, phrase and subject had been carefully labeled when examined and filed away in her mind, became an insufficient barrier before the emotional storm which now overpowered her intellect.' This passage appears to convey a rather definite

sensing of a repression instituted and maintained by the ego—a repression effected at the command of the superego, Dr. Page seems to say—together with the subsequent failure of this repression and the resultant overwhelming of the ego, rendered helpless against the onslaught of the forbidden impulses.

Dr. Page makes some reference, too, to what we term regression, by which we mean today, of course, the reaching back towards infantile objects and means of instinctual gratification, a phenomenon which in varying degrees is present throughout the whole range of psychopathological phenomena. Dr. Page speaks of 'insanity' as 'essentially the reduction of mental operations from higher to lower planes of action. While the same fundamental laws of mental action prevail through life', he continues, 'the purposes, promptings, and springs of action in the mature mind of a sane man are not transparent and are not easily comprehended. But the conditions are often otherwise with the insane, where the thoughts and actions are true to nature . . .'—or, as we might say, the gratification of regressive tendencies, of impulses from the id, is undisguised. As Dr. Page puts it, 'the egotism of sense has superseded the ego of reason'. In this respect, he adds, 'insanity is akin to childishness'.

What Dr. Page has to say about dreams is certainly not without interest, despite its somewhat confused and obscure phraseology. It was 'a natural law of the mind' that Isaiah was referring to, he says, when he wrote: 'It shall even be as when a hungry man dreameth, and behold he eateth; but he waketh, and his soul is empty; or as when a thirsty man dreameth, and behold he drinketh, but he awaketh, and behold, he is faint'. For, as Dr. Page had earlier remarked, 'Intense desire, and cravings which cannot be gratified, for the time being at least, stand in the same relations to the mind as do the repressed emotional sentiments or suggestions. Although of milder force, and innocent of the like after-effects, they come into the consciousness in the same spontaneous manner whenever the reasoning power of the mind is off guard.' In dreaming and delirium, then, what Dr. Page calls reflex mental action—

presumably mental action not in the conscious control of the subject—'revives the substance of thoughts and ideas which have been impressed upon the mind', that is, the (repressed) ideas which, in Dr. Page's parlance, have become linked the more closely to the personality and been rendered the most aggressive thoughts in the mind. The serious omission in this process of revival, he goes on to say, 'is the value sign annexed to each proposition, which . . . may qualify in various degrees, or transpose, the entire sense of the phrase. It is clearly evident that the mental mechanism and the reverse use of idioms are responsible for the spontaneous reappearing of interdicted thoughts and feelings.' Despite its somewhat obscure wording, this would appear to be a clear reference to the displacement, distortion and disguise which are the *sine qua non* of the emergence from repression, in dreams, as also in neurotic symptoms and in character traits, of 'interdicted thoughts and feelings'.

Finally, Dr. Page calls attention to the lack of correspondence between the degree of self-abasement expressed in self-accusatory trends and its justification in reality; 'the insane who falsely accuse themselves of moral obliquity and criminal conduct, who suffer untold agony in anticipation of retribution for their imaginary crimes, may be looked upon as not only innocent of intentional wrong-doing, but as especially conscientious in the discharge of their duties'. Freud called attention to the same phenomenon just twenty-five years later. In Mourning and Melancholia (1917) he speaks of how 'a good, capable, conscientious woman will speak no better of herself after she develops melancholia than one who is actually worthless; indeed, the first is more likely to fall ill of the disease than the second'. The difference is, however, that Freud made one further clinical observation which supplied the psychological key to the clinical picture, to the paradox to which Dr. Page alludes—an observation leading to the discovery that the self-accusations in question are really directed against a love-object which had been incorporated by identification into the ego.

The statement that scientific pioneers often have their pre-

cursors is generally true in only a partial sense—in the limited sense that a flash of intuition or of insight, however extraordinary and of the stuff of genius it may be, is one thing; to translate intuition into scientifically established fact, quite another. If Schopenhauer was a precursor of Freud in the respect mentioned earlier in this essay, it is not clear that Dr. Page was also.

For there can be little question of any real identity between the 'repression' which Dr. Page discusses and the repression of which Freud was able to demonstrate as well the mechanism as the prevalence in both normal and abnormal mental life. While the passages already quoted seem to indicate a certain sensing on Dr. Page's part of the phenomenon of repression as first scientifically demonstrated by Freud, it is not clear, taking his article as a whole, that this is altogether the case. In one place he seems to make repression synonymous with what we should be more likely to call inhibition, saying that 'while a mental fault of self-distrust, fear, and emotional repression develops into insanity in comparatively few cases, the health and happiness of thousands are reduced, if not sacrificed, through this unfortunate habit'. Here, clearly, Dr. Page is speaking of neurosis (and its wide prevalence) or, more specifically, of what we should think of as the inhibitions which represent repressions or defenses motivated by anxiety; and he adds that 'the seeds of such mental disability are usually sown at an early age in the life of the person afflicted'. (It might equally be noted that, similarly without knowing it, Dr. Page gives an accurate description of the sufferer from compulsion neurosis in speaking of those who 'fill their minds with propositions which must be denied, and exercise over-caution regarding that which is false and wicked. . . . They pursue the journey of life burdened by a sense of responsibility, questioning this and doubting that, until their rational strength of purpose is neutralized by a vague sense of trepidation.' On the other hand, it is less easy to say just how Dr. Page conceives of 'repression' when he states that 'insane, irresponsible exhibitions of familiarity with the language of the slums can be charged to repression in connection with aversion'; for while repression is

certainly in some sense connected with 'aversion', the irresponsible exhibitions referred to can only be charged, as we should express it today, to the escape from repression of impulses previously maintained in that state. On the whole, in fact, it would appear that what Dr. Page is principally referring to in his use of the word 'repression' is repressive methods of education and upbringing (with their 'adverse consequences'), and the harmful influence of an excessively severe morality; and indeed the entire latter half of his article becomes a homily directed against the inculcation by elders and teachers of 'extreme ideas with regard to religious duty, holiness, election, eternal torment, etc.'. (In this, old and new might be said to meet in the form of New England and the Old Testament; an entirely regrettable combination, as Dr. Page expends much space in setting forth.)

Dr. Page is at any rate talking about certain of the raw materials, so to speak, of repression and 'repressed emotional sentiments'. It is true that, owing to its discursiveness, confusedness, and what must necessarily seem to us today naiveté, however understandable, his article will create an impression upon the reader which falls rather short of its real deserts; his light is considerably hidden under a bushel. For, while it would certainly savor of hyperbole to describe Dr. Page's paper as 'chaos illumined by flashes of lightning', it is still quite clearly the fact—as I have tried to indicate in the passages quoted—that its author not only exhibited a psychological approach to psychiatric phenomena, a recognition of psychological mechanisms, which was unusual in the period in which he wrote, but sensed however dimly and falteringly the operation of a mental mechanism which Freud was on the eve of subjecting to scientific demonstration. With all due reservations, Dr. Page stood, in this respect at least, well in the vanguard of his American contemporaries.

PSYCHOLOGICAL AND PSYCHODYNAMIC ASPECTS OF DISTURBANCES IN THE SLEEP MECHANISM

BY CHARLES DAVISON, M.D. (NEW YORK)

Disturbances in sleep consisting of insomnia or hypersomnia (somnolence) can be divided into two main categories: those associated with lesions of the central nervous system and those of psychogenic origin. Normal sleep is essentially a biologic function governed chiefly by the hypothalamus. The fact that man is able to fall asleep in a conscious or unconscious attempt to escape certain emotional difficulties, or to keep awake in emergency situations or under deep emotional strain, would indicate that the higher cortical centers also play an important rôle in the regulation of sleep through their influence upon the hypothalamus. Men like Caesar, Napoleon, Freud and others were able to sleep or keep awake at will.

It is well to bear in mind that cortical activity does not cease during sleep. Discoveries have been synthesized in sleep and dreams. Otto Loewi, who discovered the action of acetylcholine on the transmission of nerve impulses, dreamed about it, woke up and recorded his ideas. Kekulé, who advanced the structural formula of the benzene ring, wrote, 'I was sitting and writing but the work did not progress; my thoughts were elsewhere. I turned my chair to the fire and dozed off. Again the atoms were gamboling before my eyes. This time the smaller groups kept modestly in the background. My mental eye, rendered more acute by repeated visions of the kind, could now distinguish larger structures of manifold conformation: long rows, sometimes more closely fitted together; all twining and twisting in snakelike fashion. What was that? One of the snakes had seized hold of its own tail and the form whirled mockingly before my eyes. As if by a flash of lightning, I

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awoke. From this time on I spent the rest of the night working out the consequences of the hypothesis.' Many similar illustrations could be given, all of which go to prove the presence of cortical activity during sleep.

It is well known that the hypothalamus is the most important vegetative center of the nervous system. It plays a part in the control of water and carbohydrate metabolism, the maintenance of normal sleep rhythms and the stabilization of body temperature and cardiac, respiratory and gastrointestinal functions. In addition it has an important rôle in the mechanism producing such emotions as fear, anxiety, anger, etc. The ill effects upon the bodily and especially the visceral functions which may result from such emotional disturbances are matters of record. Finally, the hypothalamus by means of its pathways is in intimate connection with the cortex, thalamus, basal ganglia, mesencephalon and brain stem. Disturbances in sleep are the result of a disruption in the integration of this complicated mechanism, caused either by destructive or irritative lesions or by psychogenic factors. Conversely, psychological disturbances may arise from some minor interference with the sleep centers and their pathways.

I have observed about three hundred cases with sleep disturbances, fifty-seven of which came to autopsy. Those with organic disease will be presented elsewhere except for two cases of narcolepsy with electro-encephalographic changes, because in these the hypersomnia was undoubtedly partially caused by psychological factors.

Until recently, it was thought that the state of sleep was merely constituted by a diminution or lessening in the general biological activities of the individual. The act of sleeping, however, must also be considered a fundamental psychobiological protection against mental and physical exhaustion which helps the individual to keep up his instinctual equilibrium; it is a nightly regression associated with a temporary denial of reality and an apparent blocking of certain motor activities. Sleep or somnolent states may thus assume the character of a psychophysiological defense mechanism against

dangerous collisions between the individual's drives and the surrounding world hostile to his instinctual demands. Freud states: 'Somatically, sleep is an act which reproduces intrauterine existence, fulfilling the conditions of repose, warmth and absence of stimulus; indeed in sleeping, many people resume the fœtal attitude. The feature characterizing the mind of a sleeping person is an almost complete withdrawal from the surrounding world and the cessation of all interest in it. . . . The libido is carried to the point of restoring primitive narcissism, while the ego returns to the state of hallucinatory wish fulfilment.' Freud also showed that sleep has a state of activity of its own, evidenced by dreams. This was proven experimentally by Pötzl. Patients who were shown a brightly colored picture for about one hundredth of a second were asked to relate what they had seen. Parts of the picture were not remembered (i.e. were repressed) but appeared in dreams the following night. If we accept Freud's theories of the unconscious, repression, regression and dreams, then we shall see that sleep disturbances (insomnia and somnolence) in some of the psychoneuroses, in twilight states and somnambulism and even in some organic diseases are for the purpose of avoiding an unpleasant reality or unacceptable instinctual drives.

In nonneurotic individuals, external or internal exciting stimuli, such as unusual external irritations, major excitements from the previous day or unpleasant visceral stimuli due to vascular, respiratory, gastrointestinal or other diseases, may evoke sleep disturbances. In the neurotic, however, sleep disturbances caused by psychic stimuli are largely dominated by profound repressions. These repressed psychical stimuli create conflict and tension and wish to avoid or solve the conflict. This tension is mainly the result of the relative weakness of the ego and the strength of the repressed drive. Increased repression in some psychoneurotics creates tension which ultimately leads to sleeplessness and more rarely to somnolence.

Psychoanalytic studies of psychoneurotic patients have shown several specific responsible factors, the most important of which are repressed sexual wishes, desire for omnipotence, death

wishes and the guilt feelings arising from them. The day's residue is associatively connected with repressed instinctual wishes which push forward with greater force at night during the period of falling asleep, or in sleep itself in dreams. Emotional *expectations* arising from incestuous and masturbatory wishes seem to determine the type of sleep disturbance—sleeplessness or somnolence. When the expectation is an agreeable one, that is, when gratification is likely, there is a tendency to somnolence while disagreeable expectations tend to produce insomnia which, incidentally, is the more common symptom. Thus two of the patients in this study retreated in their sleep in order to obtain incestuous masturbatory orgasm, an hallucinatory gratification of repressed infantile sexual wishes. In one of these, a reversal to insomnia took place when guilt and fear of these wishes became too powerful.

Case One: [1] The patient, a middle-aged woman, had been suffering for two years from attacks of compulsive sleep of varying depth and duration accompanied by intractable nocturnal insomnia. She had had irregularly occurring attacks of 'weakness and fainting spells' since the age of sixteen. Disagreeable incidents preceded these attacks (once she was unable to flee when a fire broke out), but they were not associated with a desire for sleep.

Six months prior to her present illness, the patient experienced extreme drowsiness and weakness during the late afternoon hours, whereupon she had to go to bed and sleep for as long as fifteen hours although she had had an adequate amount of sleep on previous nights. One day no one was able to arouse her. She awoke spontaneously forty-eight hours later with no memory of the episode.

Since then there have been numerous such occurrences. The attacks are ushered in by an intense desire to sleep lasting from a half hour to several hours. She unsuccessfully tries to fight them off but unless she is put to bed she falls to the ground. She may then pass into a perfectly quiet slumber or she may lapse into a state of restless sleep during which she utters phrases or bangs her head against the rails of the bed. During the last few months,

[1] This case will be described in greater detail by Dr. Clarence Oberndorf and Dr. Leo A. Spiegel in a subsequent publication.

upon falling asleep at night she has had terrifying nightmares in which she saw monsters and people with horrible faces. These disappeared as soon as she opened her eyes.

Her father is eighty-five years old and suffers from senile psychosis. Her mother is well at seventy-four. An older brother died from a cerebral accident. She married at nineteen and has two healthy sons.

Neurological examination disclosed dragging of the right foot on walking; coarse, irregular tremor of outstretched hands, more marked on the right; right hemiparesis; right hypalgesia with sensory disturbances for all modalities of the right side of the body and face; right hyposmia; diminution of hearing in the right ear. There were no pathological reflexes.

Laboratory data including electro-encephalographic studies were negative. There was no difference between the waking and the hypnotic electro-encephalographic tracings.

While under observation the patient's behavior was normal except that on some days she seemed dull, whining, sulky, childish and on the verge of a tantrum. Such moods and personality changes were often either the forerunner of, or merged into a drowsy state. On such occasions her movements were slowed; her face was pale and presented a drawn, haggard appearance; the eyelids drooped and the eyes were glassy. During this state she vomited persistently, complained of drowsiness and weakness, and occasionally fell, sustaining injuries which were nearly always localized to the right side of the body. She either recovered from these drowsy periods or lapsed into deeper somnolence. Neither in her normal state nor during somnolence did she reveal her thoughts. When interviewed she appeared tense and violently scratched and tore at her right arm, breast and external genitalia; she was not aware of these acts until they were brought to her attention. In subsequent interviews, when she was reluctant to speak of a scene dealing with intercourse, she lapsed into a semiconscious state in which she reënacted some of it. Upon regaining consciousness she was unaware of what she had done.

Hypnosis was induced with ease whereupon she was able to recall some of the amnestic gaps. One day she related the following dream: 'I was tied down on a couch with a rope and forced to have intercourse. I had to have it twice. I struggled and kicked. I don't know with whom.' Analysis of the dream revealed

that she had had sexual relations with her father from the age of six until forty-two when she became ill. The first experience was forced upon her and produced terrific fear. At the age of nine or ten, she became less frightened by the sexual act and experienced intense jealousy of her mother, especially after she had witnessed several conjugal scenes between her parents. At twelve and one half she seduced a boy of sixteen; at nineteen, because of her father's objections to this boy, she married another man but continued to have extramartial relationships with both her father and first lover. She considered her husband an inferior person and when she had intercourse with him she thought of her father and her lover, both of whom were 'violent and passionate' and practiced certain sadistic acts which she missed in her husband. Her present illness began with the death of her lover, twenty-eight years after her marriage; her somnolent state evidently represented her desire for sexual gratification with him. After relating the story of her incestuous relationship, her condition improved. The attacks of drowsiness ceased completely, the vomiting and falling episodes became less frequent, and her nocturnal sleep improved. In the past three years she had only three attacks of somnolence and a few drowsy spells.

Case Two: The patient, aged thirty-five, the youngest of eight children, suffered from ejaculatio præcox, guilt regarding masturbation and drowsiness. He had a strong attachment to his mother with whom he slept from childhood until he was fifteen years old, at which time his father insisted that this habit be discontinued. Shortly afterwards the patient entered into a state of somnolence diagnosed by the family physician as sunstroke. This semicomatose condition temporarily cleared up but only after the mother allowed him to sleep with her again. The patient recalled in analysis that both during this somnolent state, and when just awakening from it, he had the feeling that he had 'put on an act'. Later, the mother attachment was partially transferred to an older sister, Mary, with whom he also slept occasionally. From the age of ten he masturbated frequently with incestuous fantasies of mother and sister. The girls with whom he had affairs, except the last one whom he met during his analysis, were always older than he was and always named Mary. In his sexual relations with these 'Marys' he frequently felt like a little boy with a big sister.

During subsequent somnolent episodes the sleepiness and drowsi-

ness were generally preceded by numbness of the extremities and great fatigue or actual exhaustion, usually occurring during the early part of the evening (six or seven o'clock). At such times his arms and legs seemed to 'give way' and he then fell asleep. He believed during these attacks that he was 'a little boy fooling around', and said, 'I would like to or I am going back to mother's womb'. A typical dream of his was: 'A woman's legs surrounded me and I went into her vagina'. He frequently dreamed of swimming—a normal and pleasant act in his sleep, but one accompanied by dyspnœa in actuality. All his associations, dreams and fantasies indicated that he was comfortable in his mother's womb but nevertheless swimming was accompanied by respiratory difficulty. Of additional interest was the fact that the patient, an Englishman by birth, was continually struggling to return to his mother and sister Mary, whom he had left in England ten years previously. During his relationships with various girls this desire became even more powerful, indicating his wish to escape them and, at the same time, to return to his mother's womb.

At one point in the analysis there was a reversal in the sleep mechanism: the prenocturnal hypersomnia was replaced by nocturnal insomnia because he developed guilt feelings about masturbating with incestuous fantasies during the night. He wanted to free himself from his mother and dreamed: 'I ran to my parents' bedroom when they were having intercourse. I wanted to kiss mother goodbye. I still had a slight feeling that I wanted to get into bed with her.' Analysis led to the disappearance of both his insomnia and ejaculatio præcox.

Case Three: A thirty-four-year-old man, single, deeply attached to his mother, suffered from pulmonary tuberculosis. During his illness he experienced temporary bilateral blindness which proved to be hysterical.

Following thoracoplasty he inflicted injury to his almost healed wound in order to receive special attention. Later he had several attacks of 'unconsciousness' lasting from twelve to thirty-six hours. I saw him during one of these attacks and found no neurological changes. When I prodded him and observed to other staff members that this was a case of conversion hysteria, he awoke, answered some questions, and said, 'Let me alone'.

Further conversations with him disclosed his dependency upon his mother but deep analysis was not attempted. His state of un-

consciousness represented a return to the protectiveness of his mother's womb—a flight from the reality of his illness and other repressed drives.

It is generally accepted that powerful repressed aggressive impulses and the ensuing strong feelings of guilt which are prevalent in melancholia, manic depressives and some psychoneuroses lead to sleep disturbances, usually insomnia. Somnolence in these conditions represents either an attempt to refrain from the active impulse to kill, or by means of dreams, actual fulfilment of this impulse. During psychoanalytic treatment some patients become drowsy at times or even fall asleep as a defense against aggressive impulses towards the analyst. By falling asleep the individual feels that he is robbed of motility and thus prevented from carrying out his hostile wishes.

It is well to remember that guilt and fear or the need for punishment also play an important rôle in sleep disturbances without psychosis. Sleep is avoided or desired because of an unconscious instinctual temptation or an unconscious expectation of punishment. In most sleep disturbances, the state of sleep unconsciously represents temptation and punishment simultaneously. It is not only the pricks of conscience that interfere with sleep but also the instinctual temptations which by day were too severely restrained by that conscience. The fear of dire punishment may be so powerful (case four) that the patient is kept awake for long periods in order not to succumb to his forbidden wishes or to injuries (especially castration) arising from his accession to these wishes. But the anxiety which produces insomnia in one individual may be responsible for somnolence in another because he fears that if awakened he will be incapable of resisting the temptation to carry out his powerful incestuous masturbatory or aggressive wishes in reality. In *pavor nocturnus,* one of the most frequent sleep disturbances in children, it was noted by Willey, Berner and others that the patients are full of feelings of guilt derived from forbidden impulses such as incest, masturbation, the witnessing of sexual acts of parents, death wishes against parents,

etc.; they cannot go to sleep for fear of punishment by death. In adults, too, insomnia may in some cases express fear of death, while hypersomnia in others represents suicide for fear of carrying out forbidden impulses. This fear of dying, well known to psychoanalysts, may be associatively connected with death experiences in childhood when a relative died in sleep, seemingly as a punishment for something he was not supposed to do.

Some observers (Jekels, Federn and others) believe that the ego disintegrates during sleep. Jekels goes a step further and states that sleep is closely related to and is synonymous with death. Definite physiological proof for this assertion is lacking. We know that physiological activities, and even cortical function as evidenced by dreams and electro-encephalographic tracings, continue during sleep, although this activity is either altered or reduced during sleep, for the electroencephalogram in the waking state is slightly different from that of sleep. On the other hand, there are numerous literary references to sleep as a psychological death. In Homer's Iliad we find:

> 'Sleep and Death, two twins of winged race,
> Of matchless swiftness, but of silent pace'.

Sir Thomas Browne in Religio Medici says:

> 'Sleep is a death; oh make me try
> By Sleeping; what it is to die,
> And as gently lay my head
> On my grave, as now my bed.'

And in Hamlet's well known soliloquy:

> . . . 'To die,—to sleep;—
> To sleep! perchance to dream:—ay, there's the rub;
> For in that sleep of death what dreams may come, . . . '.

The following cases (four and five) illustrate the relation of insomnia and somnolence to sleep and death, fear of castration, aggression, guilt and the need of punishment.

Case Four: A woman of sixty-two had been suffering from insomnia for about six years. It had increased during the last six

months, following the death of her husband. Six years prior to his death a colostomy had been performed for carcinoma of the rectum. Before this operation her sexual life with her husband had been normal. She had three children. After the operation he became impotent but insisted on mutual masturbation, an act which revolted her and left her ungratified. She fantasied and dreamed of her husband's death with accompanying guilt feelings. When her husband died her guilt became intensified and she developed intractable insomnia which could not be controlled even with the aid of powerful hypnotics. She slept only for short periods of two or three hours and was awakened by frightening dreams of her own and her husband's death. During the early part of her treatment she was markedly anxious and depressed. At first she was very reluctant to discuss her marital relationship during the last six years but after working through this material she became calmer and for a period was able to sleep better. She revealed under treatment that she had had two similar episodes of insomnia, one following the birth of her last child, a premature baby who was not expected to live. She had been afraid that this child would be handicapped physically if he lived, and recalled death wishes toward him associated with tremendous feelings of guilt. Another episode occurred fifteen years before the colostomy when a brother of hers who was in business with her husband died shortly after her husband had released him from partnership against the advice of her family. She believed that she was responsible for his death. Further interviews revealed a history of childhood *pavor nocturnus* associatively connected with a strong attachment to her father and death wishes towards her mother.

Case Five:[2] A sixteen-year-old boy's most prominent symptom was sleepiness and difficulty in concentration. For three years drowsiness had interfered with his attentiveness and ability to concentrate at school. He occasionally fell asleep at school. When he came home after school he would lie on the bed, motionless, sluggish and frequently dozing. He had masturbatory fantasies of raping and killing a girl. The guilt arising from this fantasy led to thoughts of suicide for which sleep was the substitute. He said, 'In sleep one is motionless and dead. Dead people can't move and look as if they're asleep.'

[2] Dr. S. Kahr was kind enough to let me use this material.

Sleep and death were also equated with fantasies of being in the womb. A dream in which he equated suicide and regression to the womb expressed the solution of his conflict: 'I was flying in an airplane. I was killed. I was accidentally shot. The plane landed. I left a poem. Then my plane flew out to sea so that I was able to outdistance my pursuers. I died and was buried at sea.'

I should like further to elaborate the relationship between sleep and death by the statement of another of my patients: 'I enjoy sleep now more than ever; it's the only enjoyment I have. It's an escape for me. When I hear of people dying, I don't feel badly and I can look to death without emotion. Death to me is not a mystery; it looks peaceful; it's a relief.' Every psychoanalyst and psychiatrist is familiar with similar attitudes.

Psychoanalysis has established the fact that melancholia with its attendant insomnia is an illness of strong oral aggressive drives in which the patient feels in need of severe punishment for having incorporated one or both parents. That the gratification of oral wishes promotes sleep can be noted in children, adults and animals, all of whom tend to fall asleep after a heavy meal. The repression of powerful oral drives may result in severe sleep disturbances usually in the form of insomnia. One of Abraham's patients suffered in childhood from an ungovernable oral impulse accompanied by masturbation. Every attempt to frustrate these gratifications resulted in long periods of sleeplessness. Isakower suggested that in the act of falling asleep primitive 'ego feelings' are reënacted and the mental state of the sleeper becomes identical with the primary narcissism of the suckling. Individuals struggling with these strong oral needs may either accept this feeling and sleep excessively or reject it and develop insomnia.

Simmel, who treated a number of drug addicts, found that their craving for the pharmacotoxic effect of a particular narcotic expressed the wish to repeat the orgastic sensation of infantile masturbation. He noted that the unconscious wish fantasies accompanying the infantile masturbation were of a decidedly aggressive and destructive nature. Bedtime drug

addicts have to give up autoerotic narcissistic fantasies of a destructive nature during the day and are obliged to assign this extra task to the narcissistic condition of sleep during the night. They must resort to narcotics or hypnotics to fall asleep in order to safeguard themselves against committing aggressive acts. Normal individuals with an exaggerated conscience wake up from their sleep when they are exposed to overwhelming aggressive impulses, while psychopathic individuals with a weak conscience fall asleep under the same circumstances.

A few words should be said regarding sleep in somnambulism, twilight states and narcolepsy. It is well to remember that sleep is not accompanied by absolute muscular relaxation, and that both humans and animals frequently perform certain active movements during sleep in addition to the carrying on of normal visceral functions.

The psychogenesis of somnambulism and twilight states is the same as that of other psychoneuroses except that in somnambulism the motor activities are less blocked. In somnambulism actual sleep does not appear to be disturbed except in its function as a defense mechanism against the collision between the prohibited instinctual demands and reality. Sleepwalkers, like ordinary dreamers, perform in their somnambulistic states actions which they avoid performing in their waking states. In somnambulism and twilight states the individual uses his motor or, if you wish, aggressive apparatus by actually acting out or perhaps avoiding unconscious fantasies. The somnambulist's superego releases overt motor action for the purpose of gratifying or running from infantile instinctual demands. Sleepwalking thus serves as a defense against the gratification of forbidden instinctual demands and at the same time serves as the gratification itself. Somnambulistic children try to escape from their forbidden repressed incestuous masturbation fantasies which have been revived in their dreams but they always end at their parents' or parent substitute's bedside. Sleepwalking becomes a compulsive act which is a means of avoiding anxiety, but the moment the compulsive act is interrupted anxiety reappears. Sadger, who made an extensive study

of sleepwalking, found that the foremost wish of the sleepwalker was to climb into bed with a childhood loved object. Sleepwalking and moon walking are symptoms found in hysteria and epilepsy. (Charcot, incidentally, also described hysterical sleepiness.) In so-called moon walking, the moonlight is reminiscent of the light in the hand of a beloved parent. The fixed gazing upon the planet probably also has an erotic significance.

I observed a patient who developed somnambulism at puberty. He always ended at his mother's bed. Immediately upon touching her bed or if his name was called, he awakened in a state of anxiety associated with pallor, perspiration, palpitation and at times actual fainting. Ordinarily the somnambulist wakes up when called by name while noises and collisions with objects often fail to bring about a return to consciousness.

Narcolepsy, although an organic disease, may either be greatly influenced—as illustrated by the cases to be discussed—by psychogenic factors or it may be purely psychogenic. The disease is characterized by repeated fleeting attacks of sleep occurring during the day, usually but not always associated with muscular tonelessness known as cataplexy. Gelineau, who first described the disease, considered it a 'rare neurosis characterized by an invincible need for sleep, ordinarily of short duration, occurring at longer or shorter intervals of time, often several times during the same day, forcing the subject to fall to the ground or lie down to avoid falling'. The disease has been divided into true, idiopathic and symptomatic narcolepsy.

Daniels' statistical analysis shows that narcolepsy usually develops during adolescence or in young adulthood. Seventy-five per cent of the cases reported appeared before the age of twenty-six. A person afflicted with narcolepsy feels and appears well, may be able to earn a living and shows few if any signs of abnormality other than attacks of sleep and muscular tonelessness. An irresistible desire to sleep may occur several times daily, its duration varying from a few seconds to several hours. Consciousness is preserved in most cases. Some patients have

a feeling of having gone through some terrifying dream. While in the narcoleptic state he may see and hear things which are found to be visual and auditory hallucinations. Amnestic states have also been reported. Disturbances in sexual function—usually impotence—has been known to follow narcoleptic symptoms. Orgasm, muscular tonelessness and laughter or laughter alone may lead to sleep. Boredom and monotony also favor its onset.

Cortical, subcortical, diencephalic and endocrine lesions have been postulated. Some investigators because of the frequent association of narcolepsy with obesity considered it to be of endocrine, especially pituitary origin, or a disturbance of the vegetative centers together with the endocrine system. Some believe that there is a kinship between some forms of epilepsy and narcolepsy.

The psychogenic elements of narcolepsy cannot be totally ignored. Its onset at about the time of puberty, the terrifying dreams, the sexual factors and the sleepy state following laughter or some emotional stimulus (or lack of stimulus) strongly suggest that this disorder can be precipitated by emotional factors or may actually be psychogenic in origin.

In some cases of narcolepsy, according to Simmel, an attack of sleep may symbolize the passive experience of the death of the patient as a retribution for a death wish against a hated parent or person. In falling asleep there is also an inhibition of the discharge of the aggressive impulses against that person. In some instances, as in case six in which the patient's sleepy state, especially in his father's factory, may have been a hostile act against his father, the repressed aggression achieves expression in the defense itself.

Case Six: A young man of thirty-three had had encephalitis lethargica at the age of eleven. When he recovered from his illness he was slow in all his movements, did poorly in school, was irritable, had laughing and crying spells and felt sleepy most of the time. Even after sleeping for fourteen or fifteen hours he frequently found himself dozing off. The sleepy state was often preceded by a feeling of weakness, exhaustion and utter prostration. Reading

frequently precipitated an attack. In order to keep awake in emergency situations he resorted to large quantities of coffee and benzedrine sulphate.

Neurological examination disclosed slight masklike facies; slow, halting speech; lack of associated movements of the right hand and slight hypertonicity of the right upper extremity. There was slight atrophy of the right optic disc (probably postencephalitic).

Electro-encephalographic examination revealed diffuse cortical involvement indicated by the frequent short runs of slow waves which were seen diffusely but were most marked in the frontal and motor grounded leads. This suggested involvement of the cortical and subcortical structures, an assumption further borne out by the marked changes during hyperventilation with the grounded leads. These changes were comparable with those seen in epileptic disorders but during the narcoleptic attacks the electro-encephalographic tracings were similar to those in normal sleep.

During the patient's analysis the following psychogenic factors relating to his sleep disturbance were elicited: he was cool, detached and distant, giving the impression that he felt himself superior. Behind this mask there were fears that his weaknesses would be discovered, for, despite his age and his acknowledged intellectual brilliancy, he had never worked successfully in any organization and had never achieved a secure position in society.

His fears were expressed in an extreme distrust of others and in tendencies toward aggressive behavior towards those who he felt despised him. This did not consist in actual aggressive action but in a complete withdrawal and avoidance of contact and competition with others. Ever since the encephalitis, sleep was at his 'disposal' as the safest method of escape both from internal and external conflicts. Thus he no longer experienced aggressive impulses and the fear of the demands with which he was faced lost its stringency.

The patient, the younger of two sons, was largely reared by a domineering father who had successfully enlarged an inherited fortune and had become a leading industrialist. Since his first son had become incapacitated by the loss of his eyesight at the age of four, the father attempted to develop his second son into a model of ability and perfection. From early childhood, the patient was the recipient from his father of a mixture of devotion and cruelty. He constantly goaded the child to achieve new skills. The patient

was unable to oppose his father in this overbearing educational curriculum but successfully displaced his hostility to his teachers at school and a host of male tutors who constantly surrounded him. Aggressive fantasies concerning individual teachers of twenty years before were still remembered during the analysis and had not lost their activating power.

Sleep at this time became an expression of aggression. When the patient should have been working in one of his father's factories he found his way to some store room early in the day and slept until it was time for him to return home. At a boarding school abroad he occasionally slept under his bed instead of attending chapel or classes.

The patient's mother had early centered all her interest in her oldest son. The patient was left in charge of a series of governesses most of whom, he recollected, did not understand his constant need for love. One governess, however, and his maternal grandmother, the wife of a famous scientist, were exceptions. They represented the good and understanding mother-figure at all times. His separation from this governess and the insufficient contact with his grandmother were remembered as painful disappointments. There was also some evidence that even before the age of three the patient did not feel close to his mother and was aware that she rejected him—a rejection based partly on her disappointment that he was not a girl. Even in later years she had never been able to suppress her aggression against him. The family was thus divided into two camps: the father and the patient versus the mother and the older brother.

Sleep was a demonstration of his inability to face life. It expressed the thought: 'Look how sick I am, no less so than my brother', for his mother showered her affections on the other sibling. Sleep became an expression of disability and of competition in illness with his brother.

Until he was eighteen the patient also suffered from enuresis, a symptom which served the same purpose as, but was later superseded by his sleeping device. His appearance of superiority, his immaculateness, his apparent detachment served as a mask for his underlying fear of discovery and were all related to an elaborate attempt at concealing his nightly pitfalls. The usual regressive, aggressive and exhibitionistic meanings of enuresis were all present but there was one more implication. He dreamed of a 'hole in

the body' which expressed his feminine tendencies and his passivity toward his father. This passivity also acted as a provocation to punishment and was crystallized in beating fantasies. When the sleeping symptom became available to the patient it assumed some of the functions of enuresis and became a general expression of passivity and more specifically, an invitation to retaliation.

The narcolepsy in this case was undoubtedly postencephalitic and was controlled by dexedrine. Following analysis, short periods without the use of this drug, as during an upper respiratory infection lasting two weeks, did not result in a recurrence of drowsiness. Several psychogenic factors influenced the course of his narcoleptic seizures. The most important ones were: the desire to escape internal and external conflicts, the expression of aggression against his parents or parent substitutes, the demonstration of disability and of competitive illness with his brother, and finally, the general expression of passivity and a need for retaliation. The patient gained some understanding of his emotional conflicts through analysis. He succeeded in substituting new behavior patterns for his old ones. He became less withdrawn and more demanding; he took an active part in controversies and found it less necessary to resort to sleep in his flight from conflict.

Case Seven: A girl of seventeen was seen because of narcolepsy and backwardness at school. She was fairly intelligent and there seemed no obvious reason for her lack of scholastic progress. She frequently fell asleep in school although she claimed that she regularly took the specific medication, dexedrine, prescribed for this disorder.

During several interviews it was discovered that she was an illegitimate child. Ever since she was two or three years old, she had repeatedly asked her mother, relatives and friends why she didn't have a father like other children. When she was six, through the mother's influence, her father made his home with them for a brief period, during which she was very happy. It was shortly after his departure that she developed narcolepsy. In her sleepy states she constantly fantasied and dreamed about her father and as to why she could not have a father like other children. She believed that he rejected her. She also recalled that on one occasion while she was asleep a roomer in the house had attempted to have intercourse with her but she was unable to state with certitude whether he had been successful. This roomer she later

identified with her father. Her usual attitude was one of submissiveness with rare attempts at self-assertion. In her dreams and fantasies she felt that the father's rejection would change into acceptance 'if I am a good girl'.

The electro-encephalographic tracings revealed the usual changes seen in narcolepsy, a pattern closely akin to epilepsy.

As long as she took dexedrine regularly she remained alert but for some time she refused to take it with any regularity because she was unwilling to give up her daydreams. Her teachers reported that she masturbated during some of the narcoleptic attacks. Her work in school deteriorated because she slept most of the time. When awakened to take her medication she stated that she had left it at home. She was finally dismissed from school. During treatment she was encouraged to take a clerical position and did well at it. Shortly thereafter she fell in love with a man after which her narcoleptic attacks became less severe.

Undoubtedly this patient suffered from organic narcolepsy. Originally, however, there was an emotional factor which precipitated or aggravated a preëxisting organic disease. Protected by her narcolepsy she was able to indulge in incestuous fantasies, a reunion with her father, masturbation and possibly a masochistic fantasy of rejection. That the emotional factor plays a rôle is evidenced by the fact that she resorted to various subterfuges and defense mechanisms in order to avoid taking her medication. This changed somewhat when she felt accepted by a new father figure, the man with whom she fell in love and possibly the therapist.

At this point I wish to repeat and emphasize the influence of the emotions on bodily functions and the understanding and treatment of such emotions by means of psychoanalysis. Every emotional situation is invariably associated with some physiological response such as sweating, palpitation, shortness of breath, pallor, blushing, blood pressure changes, erection of hair, sphincteric disturbances, laughter, weeping and sleeplessness or somnolence. Until recently medicine has paid little attention to the investigation of these processes because they were considered as part of our normal life and without ill effects. It is quite true that in the normal, after the disappearance of the emotion, the corresponding physiological

change also disappears and the body again resumes its equilibrium. Repeated emotional disturbances, however, may result in chronic bodily changes such as hypertension, peptic ulcer, colitis, asthma, sleep disturbances, etc. This, as has been emphasized, takes place when the emotion, because of psychic conflict cannot be expressed and released through the normal voluntary channels, i.e., when it is repressed. When these repressed emotions become excluded from consciousness—from normal expression—they result in a chronic tension which in turn is the cause of the various bodily symptoms. These physical responses undoubtedly are mediated and controlled by the hypothalamus, a vegetative center, but also by the cortex and possibly other subcortical structures. The bodily changes resulting from these emotional disturbances in their early stages are undoubtedly reversible and of no serious consequence, for then there are hardly any corresponding pathological changes in the respective organs. Later, however, as in hypertension, peptic ulcer, etc., pathological changes take place and the process becomes irreversible and leads to severe organic disease. In such instances the pathological changes are secondary results of disturbed function because of chronic emotional conflict. The repressed sexual wishes, hostility, guilt feelings and other repressed conflicts lead to chronic emotional tensions which in turn result in dysfunction of the vegetative nervous system, such as digestion, respiration, circulation and sleep. It is impossible to understand or study these emotional conflicts and their early bodily changes with our present laboratory techniques. The only means of approach at present is through the psychological microscope—psychoanalysis. When new chemical or physiological means are discovered, there is a possibility that we may develop a more objective psychobiochemical approach to this problem.

From the discussion and case illustrations we can conclude that repressed psychogenic factors and the ensuing emotional tensions may lead in the psychoneuroses and even in the organic states to sleep disturbances.

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PSYCHOANALYTIC OBSERVATIONS ON DREAMS AND PSYCHOSOMATIC REACTIONS IN RESPONSE TO HYPNOTICS AND ANÆSTHETICS

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Most studies on the psychological effects of pharmacodynamic agents concern themselves with those aspects of the reactions which are uniform in all cases. This also holds true in those publications dealing with the uses of hypnotics to facilitate psychotherapeutic procedures *(1) (2) (3)*. Lindemann and Malamud *(4)* have taken a new departure characterized by their statement that 'the psychopathological changes induced by the drugs were definitely related to the whole personality and the situation within which it functions'. Also, Allentuck *(5)* found that the reactions to marihuana may differ among individuals or may be different on various occasions in the same individual.

The present study represents observations on two patients affected by chemical agents during the period they were undergoing psychoanalytic treatment. The administration of these chemicals was not part of the treatment and these observations thus represent accidental findings. The first patient will be described briefly. The psychoanalytic material obtained from the second patient threw detailed light on some of the consistent as well as on the varying reactions to pharmacodynamic agents.

The first patient was a thirty-year-old male, an engineer, whose chief complaint was attacks of extreme difficulty in breathing *(6)*. This symptom was of five years' duration at the time he came for treatment. It started when he entered the subway for the first time after having been informed by his wife that she was pregnant.

The patient had never returned his wife's love and, after two years of marriage, having a child was considered a possible solution of this impasse by both of them. With the onset

of his anxiety attacks, however, she decided to have an abortion and two years later they were divorced. A year later they remarried only to be divorced a year after that. At this time the patient began to drink whiskey and take sodium amytal to relieve his distress.

The patient frequently suffered from attacks of dyspnœa during the analytic hour for which he would take three grains of sodium amytal. His reactions to the amytal showed the following variations: 1. He would quiet down, call the physician by his first name, speak in a very friendly manner, stretch his hand across the desk and fall asleep. This type of reaction occurred after he had performed some occupational task which was difficult or after he had spent the night alone. The latter never failed to evoke an anxiety state. Under these circumstances the patient felt that the physician was his friend and his office a haven of refuge. 2. He would become more openly sarcastic and somewhat abusive. He would say, 'So you say that my difficulties are due to emotional causes. It must be so, because you must be right. I am supposed to believe this. And my symptoms are supposed to disappear. So now they are disappearing. Very obviously they are disappearing.' While talking this way his symptoms continued with unabated intensity and his hostility gained a more open expression. This type of reaction occurred when the patient was resentful because of a previous interpretation which he did not like or when he was displacing hostility toward the physician which he had for someone else. 3. The third reaction was a persistence, or at times an increase, in the patient's symptoms without aggressive behavior but with the appearance of overt anxiety. This type of reaction occurred when he felt resentful at the limited help that could be given him and wanted permission to stay in the office twenty-four hours a day and thus force the doctor to take complete care of him.

Thus it was observed that in this patient the most common reaction to sodium amytal, taken as a sedative, was sleep and a diminution of anxiety. Yet his reactions varied with his current emotional constellation and at times consisted of a

lessening of inhibition and control and thus in a more unhampered manifestation of aggression and anxiety.

The second patient was a thirty-five-year-old woman, a professional artist. She came for psychoanalytic-treatment because she was disturbed by the fact that her husband was engaged in an extramarital affair. She had neither been able to accept the situation nor had she been able to get out of the marriage no matter how often she decided to do so. She had been married ten years when she began treatment; the affair had been going on for three.

The patient was the eldest of three siblings. At the time of the birth of her sister, when the patient was four, she was taken to spend a few days with an aunt whom she disliked. When she returned home and was told that she had a sister she exhibited a temper tantrum. She said in retrospect that she had not liked the idea of the baby altogether but would have accepted a brother. When it turned out to be a sister, 'that was the last straw'.

She was always critical of her sister because, she said, 'she would fool her mother with her temper tantrums and always get her way'. Her attitude towards her sister became a mixture of rivalry and overconcern.

Her brother was born when she was eleven. On that occasion her mother went to the hospital and the patient was glad to take her mother's place 'and take charge of the house'. She also planned to take care of her brother but was soon disappointed because nurses were hired who took charge of him.

The patient's attitude toward her mother was undoubtedly full of suppressed anger but she showed open defiance and antagonism towards her only after she started college. She said that her mother always praised her excessively, 'in a fulsome manner'; 'I felt that she praised and liked something that was not really me'. The mother was overmeticulous, concerned about the patient's always telling the truth, behaving like a 'lady', always wearing the right clothes and showing the proper

manners. She created 'false moral issues' to make the patient coöperate. Thus, if she didn't want the patient to be irregular in eating or to disarrange the house, she would ask her to be 'considerate of the maid'.

The patient liked her father better because he respected her although she felt he preferred her sister. Her attachment to him was also limited, however, by a feeling—which extended as far back as she could remember—of aloofness and uniqueness. This attitude remained characteristic of her in spite of a very deep and intense attachment later to her husband.

The aloofness and uniqueness compensated for the feeling of rejection at the hands of her parents and siblings. It further represented an identification with her parents. 'Mother always helped people and this put her into a superior position.' Her father impressed a 'code' of superiority on the patient, constantly telling her that she should stand on her own, that she should use her intellect and logic in dealing with problems, and that he valued honesty very highly. Thus, the feeling of aloofness and uniqueness not only consoled her for feelings of rejection and loneliness but gave her a secondary unity with her parents in place of the feeling of complete acceptance.

There were two disturbing events in connection with menstruation: before it was explained by her mother, a girl talked about it in a rather confused way and told her that when she first had it she washed the blood away with snow. The patient found this idea distressing. After the mother's explanation, she thought that it was like urinating and was worried when it turned out to be a slow flow.

In high school her first girl friend underwent an operation for the removal of an unsightly thyroid scar on her neck. The patient became panicky and depressed about this event. Her mother, trying to help her, told her that she was probably worrying about her own thyroid. The patient became very angry 'because mother attributed a selfish coloring to my high altruistic feelings'.

At a somewhat later period, she and other girls felt sorrow

and envy over 'men's rugged possibilities' and drank ginger-ale, fancying that it was rum, singing Fifteen Men on a Dead Man's Chest 'in a rough manly fashion'.

Her first attachment to a man outside the family appeared in college. Although he made love to her for a year, she never permitted him intercourse. She often criticized him and there were frequent disagreements. She discussed her difficulties with his roommate who was poor, of foreign birth, and was excluded from the snobbish fraternities of the college. After a year she broke with her boy friend and suddenly fell in love with the other man who had been her confidant. She immediately had sexual intercourse with him and not long afterward was able to reach an orgasm.

This relationship had the following meanings for her: she could feel secure and admired by someone who, rejected by a snobbish environment, was in need of help. She obtained satisfaction from the rôle of the helper. At last she could contact someone and break out of her isolation. By reaching out towards someone who was not fully accepted by a fastidious society, she was also rebelling against her mother's standards. Finally, the relationship meant to her that she had succeeded in overcoming her painful rivalry with men and could now function as a loving woman.

No difficulties appeared until she became pregnant and they decided on an abortion. Although the abortion made her somewhat anxious, her real concern started only when she became uncertain as to whether he would marry her. At this juncture she felt completely forlorn and became depressed with suicidal fantasies. Nevertheless, the relationship continued, and not long thereafter they were married. Throughout this time, except for a brief period of great bitterness over her husband's behavior, she found sexual relations satisfactory and was always able to reach a vaginal orgasm.

Her sister died of a postpartum psychosis with schizophrenic manifestations when the patient was twenty-four years old. The patient felt 'numb' with an uncomfortable awareness that

she was not able to have adequate feelings about the event. She had two children, first a girl and two years later a boy, both of whom she handled affectionately and efficiently.

During her first analytic sessions she spoke in a pleasant, at times cleverly facetious, manner behind which she concealed her intense emotional problems. After a time she relinquished her aloof superiority a little and became more direct. Using her extremely high ideals of professional integrity, she severely criticized her husband, who was a writer. She said that he was 'selling genuine ideals down the river'. She was very certain of her conviction in all matters relating to his work, and applied her criteria stringently and with intensity when she was judging him. She did all this, however, in a poised and idealistic manner.

She was also very censorious of his behavior in having started an affair with another woman, accused him of insincerity, and wanted a completely open confession from him on everything that he had ever done, thought, or felt towards other women. She presented such sincerity and frankness as a mark of true attachment between a man and a woman.

It was pointed out to her that all her decisions to terminate her marriage and obtain a divorce led to no practical measure toward this end, that according to her own statements she had never felt attracted to any other man even during the last three years. She spoke of other men in an ironic manner, ridiculing their appearance or ideas. Thus the conclusion was inevitable that she felt completely bound to her husband because of deep feelings of worthlessness and a feeling that if she lost him she would be completely alone, forever rejected and lost, and would never become adequate as a woman again. The patient replied to this by extolling her husband's qualities and the great rôle that he played in giving her the feeling of belonging to someone, of worthiness, and in making her feel like a woman.

When it was pointed out to her that the desperation with which she clung to him indicated that the help he had given her merely served as an antidote for persistent fantasies and

feelings of the kind she had had before she felt loved by him, she reacted in the same manner as when she doubted that he would marry her—with depression and suicidal wishes.

The patient gradually emerged from this depressed state. She realized that her desperate dependency on her husband paralyzed her in her unhappy situation and that, regardless of the future of her marriage, both her excessive 'idealistic' demands as well as her clinging to him had to be resolved. After this the same reaction patterns recurred frequently but with diminishing intensity.

It was during this period that the patient underwent some painful dental surgery and on five different occasions received nitrous oxide as an anæsthesia. The length of the administration varied from two to ten minutes. The proportion of gas to oxygen delivered by the machine varied between 60 and 90 percent. She herself did not control the administration of the anæsthetic. While under the anæsthetic she had varying dreams and psychosomatic reactions.

Dream 1. There is a feeling that things go around in a circle, in a circular sequence: the dentist's instrument, the noise on the street, the feeling that this situation has occurred before, the name of her husband, and then again the noise on the street. There is a feeling that these events, these situations are right at the core of things. The patient feels that she is part of the events, yet she is an observer and throughout the experience there is the thought, 'I must tell this to Dr. Mittelmann'. She awakens with a feeling of preoccupation and concern.

Dream 2. As on the previous occasion, there is the feeling of being both part of the events and being an observer. There is again the thought running throughout, 'I have to tell this to Dr. Mittelmann'. Things try to go around in a circle but somehow the circle cannot close. This seems rather funny, and there is a distressing feeling mixed with amusement. She then dreams that the dentist, very wizened looking and thin, is making love to her and she wakes up laughing.

Dream 3. Again there is the feeling of being both observer and part of the events. She is detached emotionally and in

this detached manner is reading a great autobiographical novel that she has written. At the same time, she has the feeling that the dentist's drill, together with the drilled tooth, is somehow the core of her whole existence. She thinks how pathetic this all is and awakes weeping.

Dream 4. Again she has the feeling of circular events and of being both participant and observer. She then has an 'oriental feeling' of looking at things from a vast distance with a feeling of a sort of splendor and being part of the great space. She awakes vomiting.

Dream 5. There is again the feeling of being part of events as well as an observer. Things go round in a circular way, and the thought keeps going through her mind, 'Not Tom, not Tom', and again she awakes vomiting.

These dreams have certain recurrent features as well as elements that change with each experience. The common features are the feeling of being part of events and yet being an observer, and also a peculiar awareness, at least in the beginning of the dream state, but at times throughout it, of external events such as noises, the dentist's instrument and the dentist's activities.

These qualities of the patient's dreams during nitrous oxide anæsthesia never appeared in her normal sleep dreams although she did occasionally dream that something was occurring while she was a detached spectator, e.g., in the theater. In the nitrous oxide dreams this split is constant and it has a different quality. It can be assumed that both these qualities of the nitrous oxide dreams have to do with the psychophysiology of being administered an anæsthetic. The patient is still in contact with the outside world and would also like to retain whatever mastery she has over her own psychological processes. As a compromise, she incorporates the impressions from outside into her dream state and observes herself.

Even in these aspects of the dream state which are directly connected with the nitrous oxide anæsthesia, the patient's personality features are noticeable. The self-observation which occurred occasionally in her normal dreams is an expression of her attempt to control her emotions by means of detachment.

The result of the compromise remains as a rule unpleasant because she still considers the loss of control resulting from the anæsthesia as dangerous.

It is to be noted that the reactions of both this and the previous patient were influenced by two constant factors. One of these is the fact that they were under psychoanalytic treatment and their reactions were thus transference reactions. The other is the fact that the drugs in both cases were used for purposes other than adjuncts to psychotherapy. For this reason, probably, sodium amytal in the first patient did not lead to a facilitation of production and communication. In the second patient, the general anæsthetic represented an unwelcome paralysis of the faculties of perception and mastery.

The patient's associations to the first dream indicated that it refers not only to her current difficulties with her husband, but also to her abortion eleven years before, followed by the uncertainty as to whether he would marry her and by the resultant depression. It also refers to her unsatisfactory relationship with her first friend and thus to all her doubts about herself, her desire to establish warm contact with a human being, her desire to shed her rivalry and superiority toward men and become a woman followed by a feeling of complete rejection, worthlessness and genital injury as a result of having reached out, dropped her defenses and submitted to sexual relations.

The underlying theme of genital injury came out in a later dream, when she was not under the influence of anæsthesia, which was connected with the anæsthesia dream by the common feeling of helplessness and the need for succor by the physician.

> Dream: A young zebra is running around in circles with his hind legs close together. It is difficult to see the sex of the animal. The animal is bleeding in the back and pink blood is falling on the snow. The analyst is present, but is not particularly interested in the animal's distress. The animal looks up at him with big thoughtful suffering eyes.

One noteworthy association was that the 'running around' reminded the patient of her sister's overactivity when she became psychotic postpartum.

She thought in the anæsthesia dream, 'I must tell this to Dr. Mittelmann'. She is obviously appealing to the analyst in her helplessness, begging him to understand her plight, help her, and not repeat the same injury that she suffered from others.

Thus the first anæsthesia dream by association with the zebra refers to the patient's fantasies of genital injury shown in her distress about menstruation when she heard the story about the girl using snow to clean herself and stop the flow, and in her panic when her girl friend underwent the operation for the thyroid scar. These fantasies of genital injury were augmented by the feeling of rejection by her parents and resulted in sibling rivalry, penis envy, and a fear of punishment for her hostility.

In the subsequent dreams, occurring during nitrous oxide anæsthesia, the patient tries to solve the difficulties in the first dream. The analyst pointed out to her the implications of this dream and connected them with the patient's clinging to her husband because she considered him the solution to all her problems.

In the second dream the 'circle cannot close'. Evidently the analyst's previous interpretation meant to the patient that she must attempt to change forcibly her personality and life pattern. The circle is disrupted and she cannot obtain satisfaction in her distress. Then appears a new element in the dream: the dentist is making love to her. Her dentist, in actuality, is an elderly, thin person. In the dream he is wizened looking and funny. The patient is thus falling back on her superior, contemptuous attitude towards all men other than her husband. The dentist also represents the analyst. Thus she replies with a facetious, contemptuous, superior smirk to the analyst's attempt to make her see the problems in her attitudes toward her husband. She had had overt sexual dreams about the analyst but she greeted with supercilious ridicule and contempt all interpretations to the effect that she wanted sexual gratification—and with it the satisfaction of her longing for dependency and her desire for worthiness—from him. Characteristically, her reply was, 'That's entirely out of the question.

It is ridiculous that I should possibly have any such notion when I know that the circumstances exclude any realization'. On such occasions she also poked fun at the analyst's appearance, mannerisms or speech. In harmony with this attitude, she awakens from the dream laughing.

In the next dream there is a further reaction to the first and second dreams as they were interpreted by the analyst. She now attempts to handle the problem in a semi-detached, literary, and somewhat self-magnifying manner. This attempt, however, fails. She feels that the tooth being drilled is pathetically the core of her whole existence. She is helplessly exposed to the superior force of the injuring drill, and is deprived of all the pleasures and satisfactions of existence. In contrast to her reactions to the previous dream, she wakes weeping.

The fourth dream is a more forceful attempt in the same direction as that of the third dream. Here the self-magnification is more intense and the desire for human contact is replaced by an attempt at fusion with all objects, with the 'world'. All this is accordingly glorified. She does not succeed and rejects the whole idea and the solution. The fusion with the world may represent a revival of complete dependence on her mother, possibly a fantasy of a return to the uterus. Her disgust at this solution results in vomiting, a theme which is repeated in the fifth dream.

In the fifth dream, Tom is the name of the man whose attentions the patient has been accepting to a limited extent. He often visited the family, took her to dinner or theater, and played with the children. The patient, however, had no conscious sexual desire for him and considered marriage to him out of the question. Yet, when she spoke about the possibility of divorcing her husband and marrying someone else, the only one who came to her mind was Tom. Having rejected the solution of fusing herself with the universe, she tries to turn to a man other than her husband but also rejects him with disgust.

Thus it is demonstrated that in five dreams under nitrous oxide anæsthesia, the changes in dream content, emotional tone and psychosomatic accompaniments (laughter, weeping and vomiting) varied with the dominant emotional constellation of the patient: she experienced general distress and depression with some anxiety when her problems were directly in evidence; she experienced detachment and amusement when she reacted with aloof, facetious contempt; literary pleasure and splendor with mild elation when she attempted self-magnification and fusion with the world. She reacted with laughter to aloof facetiousness, with weeping to sorrow over her pathetic state, and with vomiting to disgust. The dental surgery activated unconscious fantasies of genital injury and their concomitant attitudes, all of which were expressed in her dreams.

SUMMARY

Reactions to hypnotics and anæsthetics in the waking state, dreams during the resultant sleep and psychosomatic reactions upon awakening, presented some consistent features as well as elements which varied with the patient's current emotional constellation. The effects of sodium amytal, taken as a sedative by one patient, were usually a decrease in anxiety and ensuing sleep. At other times it resulted in an increase of anxiety and anger. In another patient who received nitrous oxide anæsthesia during dental treatment, the consistent elements reflected the patient's struggle against the loss of her faculties of perception and mastery. The dream content and the concomitant feelings as well as the psychosomatic phenomena—laughter, weeping, and vomiting—varied with the different aspects of the unconscious problems with which the patient was struggling.

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INTERPRETATION OF A TYPICAL AND STEREOTYPED DREAM MET WITH ONLY DURING PSYCHOANALYSIS

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According to Freud we consider a dream 'typical' if it occurs in many persons with little variation, and 'stereotyped' if it recurs many times in the same person.

To the writer's knowledge no attention has been paid to a typical and stereotyped dream which appears only during analysis and is related to it. The emotional accompaniment of the dream is a feeling of resentment expressed in the complaint that the analytic session is disturbed by others in the office or in adjoining rooms whose presence robs the patient of the privacy to which he is entitled. In some cases associations are obtained, but in most instances this is so only when the analysis is far advanced and a great deal of resistance has been removed. Its interpretation, as that of all typical and stereotyped dreams, opens the way to the deepest and most strongly repressed wishes of the patient. A remarkably swift flow of associations often ensues after interpretation has been given, and the relief felt by the patient because a resistance has been overcome is immediately noticeable. The writer has observed this kind of dream in many patients and assumes that other analysts have had the same experience.

The variations of this typical and stereotyped dream are as follows:

First variation: While the patient is lying on the couch in the office, the analytic session is disturbed by the presence, or movement in and out, of the analyst's wife or some other member of his family. It is the dreamer's feeling that he cannot talk freely, that he cannot tell everything as it comes to his mind.

A male patient who had such a dream in the advanced stage of his analysis, immediately associated with it the fact that one

or two days before, while in the office, he had heard the voice of the analyst's daughter, who was telephoning two rooms away. Then for the first time, though he had had plenty of opportunity to express it before, he talked freely about the favorable impression that she had made on him. After this he was better able to relive his sexual desire for his mother and sister. The latent dream content referred to the transference situation, and through this to the incestuous love objects. The dream expressed his resistance and his disturbance and resentment at having to bring these repressed wishes to consciousness. He recalled that he had been resentful at the disturbance of his privacy when he heard the voice of the analyst's daughter. On the other hand, it transpired that not he, but the analyst, is deprived of privacy: the patient has now become interested in the analyst's daughter and wants to peep into the analyst's rooms. The whole situation is obviously an exact replica of his childhood situation.

It will not surprise us that a deeper layer contains an even more important wish. The patient's main trouble was that he dreaded any kind of human relationship, even on a superficial level, with men or women. He was impotent and had never had sexual relations. He was once called 'an Eskimo' by a girl because of his cold, unaffectionate attitude. He complained that for him a relation with another human being was impossible because he was afraid that sooner or later he would disappoint that person. What he would have liked was the impossible: 'an absolute relation', a perfect fusion, a relation in which no disagreement, difference of opinion, or disappointment is possible. In a word, what he wanted was a perfect, unbounded fusion with another person, like the fusion of two amœbas. He himself said that such a relation is approximated in intrauterine life. He then admitted that his relation to the analyst in the analysis gratified somewhat this desire, and that the only thing he feared in being cured was that he would lose this 'fusion' with the analyst.

All of this represented a marked gain in insight. Previously

he had often claimed that he had no feeling at all for his analyst, that he came, paid and left—a purely business relationship, nothing more. Thus in the deeper latent content of the dream the patient complains that his perfect relationship to the analyst as to a mother is being disturbed by his sexual desire for the analyst's daughter, who again represents his mother (analyst). Until late in his childhood his long widowed mother had shown great affection for him, as had his sister. He completely severed his relations with the family because of his fear that contact with them would revive forbidden desires and castration fear. In so doing he was attempting, at least in fantasy, to preserve his primary desire, that of being in perfect fusion with his mother in a relationship without danger, especially that of castration. This castration threat caused him to regress to a kind of mother-child relationship which was impossible in reality, but which could be satisfied in his fantasies. Thus the deep-seated latent dream content expresses his desire that the perfect fusion with the mother-analyst be not disturbed.

Second variation: In the second variation of this typical and stereotyped dream, instead of the analyst's relatives, those of the patient are present. The feeling is the same: there is no privacy and one cannot talk freely because of the presence of the patient's mother, sister, etc. During the past fifteen years the writer has heard of a great number of such dreams and has come to the conclusion that they express a resistance against the emergence of persistent strong desires for the persons in the dream. The associations prior to the dream, or those following the interpretation of the dream, reveal two latent dream thoughts. One is 'I cannot talk freely in the analytic session because if I did, I would have to talk about my forbidden desires, and it disturbs me that such desires invade my mind'. The second is 'It disturbs me that I have such desires and I feel inclined to transfer the same feelings to the analyst'.

Third variation: In the third variation of this dream, stran-

gers are disturbing factors. Strangers are in the waiting room or office during the patient's analytic hour, or they bar the way, making it impossible for him to get in. For example, a male patient dreams:

> 'I am coming to analysis and when I enter the waiting room I am disturbed by a couple, husband and wife. You prefer them, inviting the husband into the office to analyze him, and I am left with the wife in the waiting room. I take the other patient's wife for a walk and make amorous advances towards her. On returning to the waiting room, soon after the end of the husband's analytic session, both you and the husband come out. I feel that you resent my advances toward the woman and that you think I have encroached on your territory.'

There are two outstanding thoughts in this dream. One is that strangers are preferred to the patient, and the other is that the analyst resents the patient's encroachment on the analyst's territory. The patient is in reality much concerned lest someone get ahead of him. He wants to outshine everybody, he covets the woman who belongs to the other man and wants to take her away from him. Furthermore, he is afraid to assert himself for fear that others might resent it. The latent dream content expresses his concern lest he reveal that it is he who would disturb the privacy of the analyst, as he has wanted since early childhood to disturb the privacy of the parents. This has been the principal motive of the dreamer since he became entangled in the œdipus situation. The strangers, as Freud advises us, represent the opposite, i.e., the close ones, the relatives, and in the dreamer's case, the mother.

Fourth variation: In the fourth variation the dreamer is disturbed by the presence of *two* analysts. In the manifest dream content one analyst usually plays a mute rôle, sometimes as the assistant of the other. The latent dream content refers to the transference situation, and through this to a deeper latent dream content which is usually also the core of the neurosis. The writer would like to emphasize the fact that in the present paper a specific type of transference situation is described, a

transference which is characteristic of those patients who produce the typical and stereotyped dream discussed. The latent wish expresses the patient's protest at being analyzed. He wants the analyst to be his mother, to love him and not to analyze him. He protests against the analytical situation which frustrates him. He wants to cling to the analyst as to a mother. In his fantasy he knows *two* analysts, one who analyzes him and one who loves him. But the second one is mute and does not express his love.

Fifth variation: This same latent dream thought is the instigator of the fifth variation of the dream in which another analyst is substituted for the real one. The new analyst may be either a male or a female. The patient is frustrated by merely being analyzed; he therefore wishes another analyst to do the work and the real one to love him, or he would rather the analyst be a female in the hope that she will love him as a mother.

Sixth variation: Finally, in the sixth variation of the dream, the analyst is the same but the office is somewhere else, or the furniture is somewhat different, or the couch is in another location. This expresses the patient's desire *to change the situation,* to change his relation to the analyst, to reëestablish and relive the deeply craved for mother-child relationship in which he has no fears, no frustrations, no hardships, only protection and love. This is what he wants in the analysis from the analyst, and because he is frustrated he resists and his resistance appears in the dream.

The writer hopes that further contributions by other analysts to the interpretation of this type of dream will deepen our understanding of it.

THE NEGATIVE IN DREAMS

BY NANDOR FODOR, LL.D. (NEW YORK)

Freud's statement, 'There is no negation in dreams' needs no confirmation. If the dreamer notices somebody's absence in the dream, the very notice focuses attention on the absent person. Nor is attention through denial limited to dream life. When a woman lays undue emphasis on her innocence we say, 'The lady doth protest too much, methinks'. The playful injunction, 'You may think of anything but not of a hippopotamus', makes it impossible to get the hippopotamus out of our mind. In waking life it is the strength of negation that produces this seesaw effect of attention. Without stress, negatives are likely to be accepted at face value. If we ask someone if he was at home yesterday and the answer is 'no', we may give no further thought to the statement. But a stubborn insistence on having been at home will make us suspect that somebody had challenged the fact and the grounds of this challenge might be important.

The stress which compels the waking mind to think of the opposite is always present in the dream mind, but is not necessarily manifest in the dream. The dreaming of the dream is the evidence of the stress. Therefore, a simple negative fulfils the same purpose in the dream as a strong one in waking life.

Further, in waking life the negative may not hold. We may drop it as unthinkable in view of the veracity and integrity of the person in question, or the court may acquit the accused. We cannot establish the truth unless all the pertinent facts are put at our disposal, which is seldom the case. In the dream the unconscious mind is in possession of all the facts. No stranger is unknown to the dream mind, no situation is uncalled for—in the literal sense of this word. The dream is wholly subjective and is enacted for a definite purpose. Nothing can happen in the dream which is contrary to the purpose of the

dream work. Negation is simply one mechanism of preventing anxiety from disturbing sleep.

The forms which the negative takes vary. Let us first examine some simple negations:

> 'In one corner to the left, there was a fountain of pewter. I went to it and washed my hands. They were stained red, a funny color I got on them somewhere. I knew it was not blood. I started washing it off and then turned towards the window and put my hand over my eyes. In a bright sun you can see through your fingers. I saw the colors of the rainbow.'

This dream is part of a terrible lycanthropic fantasy in which the dreamer saw a woman acting like a wolf with bleeding human entrails hanging from her mouth. This woman was, of course, herself. She represented herself as wolflike because of guilt for an abortion. Had she not made the woman a stranger, she could not have stood the horror of the dream; this device decreased the tension. The same purpose is served by the denial that the stain on her hands was blood: it is a confirmation by the negative. The color *was* blood. She thinks of blood, and hedges with a critical observation. The vision of the rainbow through her closed fingers is an additional corroboration: what one sees through the fingers against bright sunlight is blood coursing in the veins. The rainbow, as a bridge, refers to birth or giving birth. As a symbol of the covenant between God and man, it envisages the resolution of her bloodguilt.

> 'I was mixed up in some stealing. I did not want to be and felt bad about it the whole night.'

Here the negative is weak and is centered on the intention. The dreamer does not deny that she is a thief. She admits she has been involved but mitigates it and pleads for consideration.

This dreamer was 'a poor little rich girl', cooped up in a magnificent home with too many restrictions and no playmates. She was always yearning for a companion. By means of the following negatives she succeeded in making a series of revelations:

'I was sitting on a bench out of doors, next to a very large, ordinary house. In the windows of each floor you could see chickens sitting row after row. They were not mine; they belonged there.

'Then came a little dog and I knew he did not belong to me. I took him with me. Later we boarded a train and the dog talked to me. I said, "Don't worry, I am going to keep you". He was happy.

'My grandmother was somewhere in the house and colored maids (which we never had) were about. They were very nice but they worried because they did not do something. My grandmother said, "Never mind, my son, the Duke of Windsor, will come and he will take care of that". Everything was all right; nobody had a bad conscience.

'I was in a large house, like a fraternity house. I knew they were college people. I think I had nothing to do with them. I walked upstairs.'

The chief complaint of this patient was that she could not get along with people, that she was afraid of them. No better setting than a fraternity house could be devised for the need to be gregarious. By going upstairs in the college she learns —in the higher school of analysis—how to be sociable. Because of this need, contrary to the statement of the dream, she had everything to do with her fellow students.

The glorified chicken coop is her parental abode where she did not feel at home and in which she indulges in foundling fantasies of being a princess. The dream bears witness to such a fantasy: if the Duke of Windsor is her grandmother's son, her father was a prince and she must be a princess. The black maids hint at guilt. Their worry over not having done something suggests the reverse: trouble over something that has been done. The denial, 'nobody had a bad conscience', establishes the fact that she suffers from one and that the escape into fantasy life failed to release her from it.

I claim that there are no half statements in dreams; the dreamer cannot speak of guilt *in abstracto*. The nature of her guilt is hidden in the same dream. We can discover it in the statements that concern the little dog.

In her princess fantasies the dreamer always had a dog. She used to stretch out her arm and lead an imaginary dog and talk to it. When she was nine years old she was asked which she wanted, a baby sister or a dog? She chose the dog, which did not stop the birth of the baby, a boy. Jealous of her position in the family, as revealed by many dreams, she fantasied this baby's destruction in utero. The dream dog is more than a dog—it can speak and it is a 'he'. It is a combination of the dog for which she yearned and the little brother whom she rejected. She states that the dog does not belong to her, yet she boards the train with it. The allusion is to an illegal entrance into a symbol of her mother's uterus. She and the dog are carried in it. The rolling wheels give rise to an undulating sensation similar to that which she felt must be caused by an expectant mother's walk. In giving assurances to the dog that she will keep him, she relinquishes her destructive fantasies and promises to hold and cherish the rejected brother.

The negative is not always openly revealed. Sometimes it is latent as in the following dream:

> 'I visited the house of Schwartz, a friend. I was on the roof. The coal man said that the roof was beautiful and so clean—the best roof he had ever seen. I was proud of the man's remark.'

Her pride is displaced from the house to the remark. The house is her own. But it is a black (Schwartz) house and an important negative is hidden in the concealment of this fact. What the dream wishes to state is that the roof is beautiful and clean but the inside of the house is very dirty. It would be with a coal man parading in it. The dreamer was very scrupulous about her looks, she was always very clean and beautiful. The roof (a cover symbol for her appearance) was satisfactory, but inwardly she was 'eaten up with neurosis'.

Sometimes the negative is so well concealed that it only emerges from the patient's associations:

> 'I am meeting a hospital nurse and ask her for a date. She explains that she has little time as too many babies are born. She is aloof, demure, well poised, and has large thighs.'

The patient began immediately to rail against his wife. She was sexually very aggressive and had no poise. He preferred aloofness, and was attracted by large thighs. Fifteen years ago he could have had an affair with a nurse of this type but he failed to follow up his opportunity. Recently he tried to find her but could not.

The dream contains two negatives, a manifest and a latent one. The manifest negative is the nurse's refusal which only serves to reveal his desire for her. The latent negative is the rejection of his wife. It is implied in the philandering desire but as it reveals his true state of mind, it is kept out of the manifest dream. The nurse is, of course, a mother symbol, a substitute for the patient's love ideal. The birth of babies hints at the root of his mother fixation: the wish to be mother's unborn or newly born baby. He cannot have the date because of the incest taboo.

Another male patient, in answer to the question whether he had any aversion to semen, replied, 'It is not natural to see it'. Asked about its smell, he said, 'I suppose I would not taste the smell of it unless it were my own'.

The curious wording conceals a negative about which no questions were asked. He denies that he tasted his own semen and simultaneously admits it by the words 'unless it were my own'.

In some instances the negative is not in the dream or in the associations but is found in comment or explanation during the narration of the dream. For instance:

> 'An old woman dies and her daughter goes to see her. . . She cannot be my mother; this woman in the dream is much older.'

Thus the dreamer denies that she wishes her mother's death. The dream is so plain-spoken that she is prompted by the forces of repression to obscure it by the mechanism of comment. This bears out the contention that the patient's immediate comments on the dream should be taken as part of the dream.

'I went up in the elevator to the fifteenth floor. Then I was told I should go to the fourteenth. (That is not connected with your fourteenth floor.) I walked down the stairs and then I saw that I was still on the fifteenth floor. It was very odd.'

The dream states that through analysis the patient has reached a higher level but must continue his analysis. Since this was not to his liking, he denied that the fourteenth floor was mine. He reëmphasizes the fact that his progress is tied up with continued analysis when, after descending, he still finds himself on the fifteenth floor.

Occasionally, the negative takes the form of doubt:

'It must have been Helen's restaurant, but it did not look like it. It could not have been, I mused, because she was in Florida.'

Here doubting serves the purpose of affirmation. Why should the dreamer have been preoccupied with Helen unless it was she of whom he was speaking?

These instances illustrate the simpler manifestations of the negative in dreams. Between denial and affirmation room exists for a gamut of qualifications. We may distinguish grades of negatives and find on investigation that they are as insubstantial in the dream as the plain and straightforward 'no'.

The joking remark, 'I did it accidentally on purpose', has a particular application to dreams. There are no accidents in dreams; every situation is deliberately contrived. If a man is struck by lightning, the dreamer may have wished that God strike him down. If he himself is struck, he may reveal his fear of God because of 'religious' guilt and a consequent tendency to self-destruction, or he may reveal a psychological crippling due to a childhood traumatic event. A woman dreamed that her brother was run over by a train which cut off both his legs at the thighs. Terrified, she immediately telephoned him long distance to assure herself that nothing had happened to him. I asked if anything had happened to her that has crippled her sexual life because her dream seemed to indicate retaliation

for a genital injury. The question hit home and elicited a flood of corroborative memories.

One cannot blame or accuse somebody of a deed in a dream without revealing one's own guilt. The mechanism of projection which we love to use in waking life is doomed to fail because the dream persons are subjective creations representing parts of our own personality and dramatizing our own attitudes and wishes.

You cannot truly wonder if something happened or not in a dream. If the dreamer wonders whether he has been bitten by a snake he admits it, whether the snakebite refers to an actual event or is symbolic of sexual aggression. Without it, the dream would have no purpose. It is its fundamental statement.

You cannot truly make a mistake in a dream. If you call a man Paul whose real name is Peter, the mistake serves the purpose of revealing a hidden tie between the two men. In that sense the mistake is intentional, therefore no mistake.

You cannot lie in a dream without revealing the truth. Here is an illustration:

> 'I find myself in a new position, in a large government office. With a start I remember that I had not told my boss I was leaving. I call up my husband and tell him to telephone and say there is sickness in the family. Then I find myself in Dean's house and she tells me that she called my old office and told them I have a career and no longer need them. I am furious with her as I like my old job best. As I leave she tells me that I have always made a lot of trouble between her and her husband and that her husband has always been in love with me, which made things difficult for her. I laugh and say that I am not interested in a man twenty years older than I, nor in a man with a mustache. Then I find myself in a large crowd with her husband near me, breathing his love and devotion.'

By lying about sickness, the patient states the truth in a roundabout way. The lie is that she has to leave her old job because of sickness in the family. The truth is that she has to change her old personality because the family situation has

made her sick. The old boss is her father and her love for him refuses to die. On the one hand she is willing to change her relationship to him through analysis and she accepts a new dependence in the service of the government (a symbol of central organization, integration), while on the other hand she is furious because Dean cuts off her retreat. Dean's husband was her manager and as such another father symbol, which is further indicated by the difference in age which does not correspond to reality.

That there is no false accusation in dreams is also brought out here. The affirmation of her love follows on the heels of its denial. You can only inspire yourself in a dream; it is she herself who is filled with these emotions. She admitted this was true by saying, 'In a mild way, we have loved each other, but always platonically'. She lies twice in the dream and by each lie she reveals the truth.

You cannot do the wrong thing in a dream without being right. This is exemplified by a dream about a wrong bus, which, for the purpose of the dream, is the right one. Only by taking the wrong bus does the dreamer succeed in revealing the latent content of the dream:

> 'I tried to be on the job at ten A.M. As I was already an hour late, I wanted to change into my uniform in the bus. It was embarrassing but I tried, without success. The blouse would not slip over my shoulder so I put my uniform over my clothes. The bus went the wrong way, to the East Side, right to the river. Ottie was sitting on my left side, and on the right a small child was leaning against me. I got off and walked two blocks back, wishing that I had taken a taxi. I did not want to embarrass Ottie. I thought she may not want to spend the money and would not accept an invitation to be my guest in the taxi.'

Ottie is a nurse, an acquaintance from the old country, and was the patient's partner when she had her own beauty parlor. Her name is a clang association with Lottie, the name of the patient's mother. In the dream she retraces her steps to birth. The blouse that would not slip over her shoulders suggests

the difficulties of her delivery; the East River is the River of Life, the amniotic water. East is sunrise, the beginning of life. She is being carried in the bus as within her mother's body. The wrong bus expresses the thought that it is wrong to want to be carried instead of standing on one's own feet. She is changing in the bus, puts on a uniform to become like 'folks', which is a hint that her isolation in life was due to the enduring spell of her prenatal solitude. Ottie is on her left side, because left is wrong and her dependence on mother has crippled her psychic life. She is beginning to stand on her own feet—leaning on herself—which is symbolized by the child leaning against her on the right. She should have been on the job at nine o'clock. Nine is the number of gestation, it stands for birth. Ten is a new beginning, a new life, rebirth. She should have been separated from her mother psychically, as she was physically, at birth. That, however, is a miracle which no child can achieve. Now, through analysis, she is making a new, symbolic transition from prenatal to adult life.

You cannot dream of a secret without revealing it. This claim is borne out by the following dream:

> 'I was with my father. We were traveling very fast because someone was following us. We got into the kitchen. We seemed to have some vital information. It seemed to be hidden in a nail. I wanted to hide it from the man who was following us. Perhaps he was a spy. So I hammered the nail into the leg of the kitchen sink near the top on the inside where he would not find it.'

It is the method of hiding that reveals the nature of the dreamer's secret. The sink, having two legs and holding water, is an excellent genital symbol, and the kitchen identifies it with his mother who presided over it. He thought that the man who was after them was his analyst. Since the hammering stands for intercourse and the spot where the nail is driven in needs no explanation, he obviously is trying to hide from the analyst a sexual fantasy or act that concerns his mother. The analyst is a spy because he tries to ferret out a secret which he refuses to share. His father, however, seems to be in on the

secret. A full knowledge of the patient's life history leaves no doubt that this sharing with father conceals a negative. In real life the patient was so frightened of his father that he could not eat at the same table with him or talk to him. Thus sharing with father stands for its opposite. It is not really of the analyst he is frightened, but of his father. It is his father who would be after him if his secret were revealed and it is from his father that he tries to run away.

You cannot give a false association to a dream without making a true revelation. After reading about Japanese atrocities against American hospital patients, a man dreamed:

> 'I am in an army hospital and the orderly is surprised that nobody attended me during the night. There was trouble and nobody cared. He asked, "Why didn't they take your heart sign?" I am too weak to answer. He takes the stethoscope and puts it to my ears instead of his own. I try to read the answer in his eyes. But one of us is wearing goggles, either he or myself. It seems he thinks I am worse than yesterday. I say in German, *"Erste, zweite, dritte, vierte, fünfte, sechste, siebente"*. There is no *achte*. I hope I have a chance to be an American.'

The patient thought that the heart sign and the missing eight stands for the eight of hearts. He used to play with German cards in his childhood. 'On the eight of hearts there was a picture of Gessler on his horse, with an arrow in his heart. It showed the tyrant dead. He wanted to have his little son Walter killed and told William Tell to shoot the apple off his son's head. . . . No, this whole thing is off. This is not the story of the eight of hearts. The eight of hearts shows William Tell fleeing in a boat across the river after he had shot off the apple.'

The mistake does not invalidate the association. The patient pictures himself as a victim of atrocities and accuses his father of having made him psychically sick. The heart sign and the stethoscope represent emotional disturbance. The fusion of identity between himself and the orderly suggests that he is now trying to play the double rôle of father and child. He

tries to grow up, to be a father to his child-self. He had an eye tic and terrible fears of going blind. The goggles protect the eye and they suggest x-ray examination which is an excellent symbol of penetrating analytic research. He hints that his eye trouble centers on his father, that the fear of blindness is a castration fear. Through the orderly and an understanding of his suffering at the hands of a brutal father, he will make his personality an orderly one. He will become an American, the denizen of a new world, free from the ties of the past.

You cannot pretend in a dream without playing the true rôle. The patient of the previous dream dreamed of touring a department store after closing hours. In the children's toy department he is told by a superintendent of the existence of a room, sealed since 1825 and opened about sixty years ago. They found buried in it a young Hungarian girl called Beckie Schwartz. She was murdered by her father. Then Beckie's father appears on the scene and he looks like the patient's own father.

> 'I decide to frighten Beckie's father and pretend that I am Beckie. I ask him why he shot me. He discovers that I am not Beckie and pursues me with a gun.'

For our present purpose it is enough to know that the patient himself realized that by pretending to be Beckie he gave himself away. He said, 'My father has crippled me for life and now he wants to shoot me because I have discovered his guilt'.

My claims about the values of negatives should not be taken too literally. The laws of dream interpretation differ materially from the physical laws of the universe. The latter are rigid, the former pliable. Ambivalence and multivalence is the prevailing feature of the mental world. Meanings in it are not exclusive but inclusive. One thing may mean everything and everything may mean one thing.

We may state with Freud that there is no negative in dreams. Yet we do find dreams that express a valid negative—by a positive—as in the case of the patient who dreamed of a date with a nurse and in the case of the man who shared his secret with his father. The positive desire for the nurse revealed the

rejection of the dreamer's wife because of the incest taboo. The positive sharing of a secret with a father whom he dreaded revealed the nature of his guilt.

We may proclaim that the dream is the guardian of sleep, yet—as Dr. Jekels recently explained—the dream has an important awakening function. This means that the dream can be both the guardian and the disturber of sleep. The latter is excellently illustrated by dreams about the telephone ringing and awakening the sleeper who finds that the telephone did not actually ring but that it was time to get up—the likes of which happen only too frequently to all of us.

The need for precision and for a clear and sharp distinction between opposites is the demand of the conscious mind—without it we would soon lose our grip on reality. To the unconscious, reality is of subjective significance. No symbol has a fixed, unchangeable value. They are in a constant state of flux; their values change like the colors of the chameleon. This tendency is well reflected in language. In primitive tongues one word, such as far and near, may express distinct opposites, a fact which has nothing to do with lack of culture. To primitive peoples, time is not an exigency and proximity and distance are not so vitally important as to us. The same disregard for precision exists in our civilized speech. The word 'act' means to do something but it also means pretending, its very opposite. 'Pay' means to square off something with money, but it also means not paying but suffering instead. 'Fencing' means dueling but also refusing to come forward and fight. 'Invention' is a discovery and its opposite, a lie. 'Go on' means leave me but also stay and continue. A cosmetic establishment on Fifth Avenue is called Beauty Bar. It is a place where beauty is sold over the counter, but it could also be taken to mean a place where one is barred from getting beautiful.

With so much ambivalence in our everyday speech, it behooves us not to lay down rigid laws regarding mental manifestations. Yet laws we must have if we are to live an orderly and logical life. Only let us have a mental reservation. Let us take our mental laws with a grain of salt.

A MECHANISM OF HYSTERIA ELUCIDATED DURING HYPNOANALYSIS

BY LEWIS R. WOLBERG, M.D. (NEW YORK)

During hypnoanalytic treatment of an alcoholic patient the mechanism of a hysterical anæsthesia became apparent and the symptom was relieved.

The patient, a radio singer of forty-two, gave a history of alcoholism from his early thirties when he began to mingle with a 'sporty' set of professional entertainers, all heavy drinkers. Shortly after his marriage at thirty-five, his voice, which up to that time had been excellent, became wavering and inferior, eventuating in a loss of his contract. Unable to find work, the burden of supporting him and his wife was assumed by his father. The patient managed to earn or borrow sufficiently to maintain himself in a state of drunkenness to the disgust of his wife and of his parents who threatened to withdraw their support. This stimulated more drinking which assumed pathological proportions after his wife left him. Physicians recommended hospitalization which his father refused to consider.

Following especially heavy drinking, the patient ran into his father's room one night, got into bed with him and related the dream that strange men were going to kill his wife. He appeared so distraught that his father sent him by ambulance to a hospital for observation and treatment. Examination revealed tremors of the hands and face, and anæsthesia of the right hand which was attributed to alcoholic neuritis. There were no hallucinations or delusions. He was sent to a state hospital where he remained two months following which he was taken home by his family, apparently recovered. He resumed drinking and was rehospitalized no less than ten times, on each occasion making a rapid recovery and persuading his father to give him another chance.

He exhibited the typical alcoholic projection of his difficulties onto casual inimical happenings in his life history. He was more concerned with the 'deadness' of his right hand than with his alcoholic habits. The numbness in feeling had persisted with periods of complete remission. Neurologically, this condition bore no resemblance to alcoholic neuritis. There were no impairment of muscular power, fibrillary tremors, trophic symptoms or alteration of reflexes; furthermore, the anæsthesia had a 'glove' distribution.

The patient was eager to try hypnosis. He proved to be an excellent subject, going into profound somnambulistic trances with complete posthypnotic amnesia. During the second week of treatment there was a spontaneous remission of the anæsthesia. The patient was delighted, attributing it to the 'expert' treatment he was receiving at my hands. The next day he failed to keep his appointment, and telephoned several hours later from a bar to say he was so certain he had been cured, he had decided to test his will power by taking a single highball. After the sixth, he was convinced he had failed, and expected me to refuse further therapy because he was hopeless and had failed me as he had failed all of his friends and relatives.

The following day he kept his appointment in a somewhat disheveled condition. He was profoundly contrite, stressing that this mishap had occurred when he was certain the treatment was succeeding. His associations, however, indicated some doubt about the progress he had made, and a fear of being unable to live up to my expectations. His father had expected accomplishments of him he could never fulfil. He had tried several years to succeed in his father's business and, when he reached the point of assuming responsibilities, he was obsessed with the fear of failure. He had then decided to make singing a career. With proper training, and with a certain amount of influence, he obtained a position as a featured singer on a radio program sponsored by the manufacturer of a well-known product. He was successful until his wife, who was a singer also, began to praise his voice and to predict that he had a

great career ahead of him. Thereafter his voice lost its pleasing quality and power.

He presented two dreams of the preceding night:

> 1. 'Instead of your being in your proper place, my wife was there. She was putting me through the same routine as you. You were in the background somewhere; also my father. It seemed that I had recently been singing and the two of you noticed alcohol on my breath and said how badly it affected my voice. Both of you advised me to stop drinking and impressed on me that drink was ruining my voice. Then the scene shifted and I was working at a responsible job. I had a position of authority. My family was all together and I was very happy. The dream ended in a kaleidoscopic picture with no sense to it.'

To this dream the patient associated the fact that he had given his wife a raw deal through his drinking. She had had confidence in him and he had played a 'dirty trick' on her as he had on me the day before.

> 2. 'I was reading a newspaper which reported your demotion from a doctor to a worker in a shoe shop because the medical authorities learned you had failed in your treatment of me through my having become intoxicated yesterday.'

Under hypnosis free associations disclosed strong competitive attitudes towards his father and towards his wife. Quitting a job his father obtained for him was in part due to a conflict over his competitive feelings. His failure in singing was associated with a conviction that he was competing with his wife who had several profitable radio contracts. He revealed also that he had secretly entertained the idea that he would learn all there was to know about hypnosis from me, and would then become a hypnotic therapist. It was part of this fantasy that he treated patients who would otherwise have come to me.

His compulsion to fail was based upon a fear of competitiveness as well as a desire to vanquish authority. When I brought this fact to his attention during the trance, and as I analyzed the existing transference reactions, he explosively avowed that

drinking was a means of revenge against his father, his wife and me. We were unalterably opposed to his alcoholism and the fact that he could not abstain indicated we had failed in our specific task to make him an outstanding person, and therefore merited demotion and punishment. Drinking was an avoidance of 'messing up' his life in trying to succeed where success was impossible. No one could expect a drunkard to be an outstanding person.

At the next session the patient related a dream.

> 'I was driving over the Williamsburg Bridge and talking to a man next to me. The man was like my uncle. He said, "I think you better watch the driving"; and I said, "What! Am I driving?" It sounds like a gag from a Charlie Chaplin picture.'

To his uncle, he associated, 'My uncle was Mr. Heel: always getting people into messes'. Under hypnosis there was little doubt that the uncle in the dream represented me and that riding in the car symbolized the hypnoanalytic process. It could not be determined in which particular way I was failing him, although he expressed the opinion that were he not being treated he could probably conquer his drinking and obtain a good job immediately. As he was talking I placed a pencil in his hand and he wrote automatically: 'Doc making *1* out of *5*'.

Soon afterward the anæsthesia returned, to his great annoyance. Other than expressing irritation that I would probably disapprove of his taking even one drink, he displayed no other feelings or attitudes in the transference. Under hypnosis he recovered a dream which had immediately preceded the reappearance of the anæsthesia.

> 'I was attending a funeral. As I watched the procession I became aware that the man being buried was my father. I rushed over to the casket to serve as one of the pallbearers, but my right hand was paralyzed.'

He was quite agitated as he related the dream, recalling the feeling in the dream that he was responsible for his father's death. He was told the symptom might represent a form of

self-punishment for guilt about his father's death in the dream.

Upon awakening, the patient remembered the dream. He repeated it as if he were telling it for the first time, and he did not remember my interpretation. He shook his hand and remarked that feeling had returned to it, adding, 'For some reason I'm greatly relieved, as if I got something off my conscience'.

Several days later under hypnosis the patient was given the following suggestion: 'I am going to bring to your mind an experience which you have forgotten because it was painful. As I tell you about the event you will reëxperience it as if it were happening again. A short time ago you went into a bar for a drink and asked the bartender for a scotch and soda. Instead of filling your order, he looked at you and sneered. Then he started to insult you in the worst possible language. You tried hard to keep cool, but you couldn't. You wanted to break a chair over his head. You looked at the man and were shocked to see that he resembled your father. In fact you had a suspicion he might be your father. While you tried to be pleasant, he continued to hurl insults at you. Finally you couldn't stand it any longer. You picked up a bottle and let him have it. The blood streamed down his face. His brains started to pour out. You were filled with guilt and fear. Do you remember the details of this experience?'

The patient was trembling with emotion. He was breathing very heavily, sweat pouring down his face. He recalled in detail all the elements of the experimental conflict. 'Now', I continued, 'when you wake up, you will forget this experience, but you will feel all the emotions that were associated with it'. The last command was repeated several times.

Upon awakening he appeared genuinely distressed. He exclaimed, 'I don't know what is the matter with me, but I feel as if the bottom dropped out of everything. It's as if there were shrouds all over and I was going to a funeral.' He wiped tears from his eyes and continued, 'Father always stopped me from doing what I wanted. I always felt he had my interests at heart, but from the way he did things I might as well have

lived in handcuffs.' Examination revealed that the anæsthesia had returned, the patient being insensitive even to burning from a cigarette.

At the next session the anæsthesia was still present. He related a dream:

> 'I had a job, but my wife kept interfering. She kept telling the boss about my drinking. My boss cut my salary from five dollars to one dollar a day. I was mad at him and told him, "You might as well cut off my hand".'

Associations again revealed a preoccupation with funerals. He had felt so tense the past few days that he was greatly tempted to take a few drinks.

Under hypnosis he began giving associations to the dream, blocked suddenly, covered his eyes with his hands and shouted, 'I can't, I won't see it'. He did not know what it was he could not see. He was then inducted into a very deep trance and reoriented to a period between four and six years of age. He was told that he would be able to open his eyes without awakening; then he was seated at a table and instructed to gaze into a small mirror which reflected the ceiling. He was assured that a scene would appear which would explain everything.

The patient watched the mirror intently. Suddenly he shouted, dropped the mirror and closed his eyes. With persistent urging he peered into the mirror, his eyes widened and with a look of horror he leaped from the chair and cried, 'I see it now; he wanted to cut off my fingers!' He was between four and five years old, in bed, rubbing his erect penis. His father discovered him and scolded him severely, warning him that boys who did that had all their fingers cut off but one. He recalled the incident with intense anxiety. The remainder of the session was spent in a discussion of misinformation about masturbation. He was instructed to remember his hypnotic experiences provided he felt he understood their full significance and would not be too frightened by them.

Upon awakening the patient recalled the entire experience stating that the first thing he saw upon gazing in the mirror was

himself with four fingers of his right hand missing; then he remembered being intimidated by his father. Considerable anxiety was still present as the patient discussed the experience. The anæsthesia disappeared. In subsequent sessions he gradually became less sensitized to the fright of the experience until he could discuss it without anxiety. The anæsthesia did not reappear throughout three years during which the patient was closely followed.

BOOK REVIEWS

THE PSYCHOLOGICAL FRONTIERS OF SOCIETY. By Abram Kardiner with the collaboration of Ralph Linton, Cora Du Bois, and James West. New York: Columbia University Press. 1945. 475 pp.

In this work Kardiner continues his fruitful collaboration with anthropological field workers, further applying his method of inferring from their reports the 'basic character' which corresponds to each culture. The basic character, as the term is used in this book, though it seems to be an elastic concept, comprises, generally speaking, what an extensive psychoanalytically informed personality study of the common man in a given group would presumably show. Certain of Kardiner's inferences from the field workers' reports possessed a broad explanatory value, accounting for many traits observed in the peoples studied; others could be confirmed by subsequent checking in the field. Hence, Kardiner's interpretations were extremely useful to his collaborators; indeed many social scientists see in this collaboration a new era in their field.

Kardiner, however, expresses in this book a certain reservation as to what can be done by his method. Dr. Oberholzer's 'blind Rohrschach' study of the Alorese picked up characteristics that Kardiner had not been able to make out. Although Kardiner's trained eye caught the importance of Alorese lack of maternal care, there was nothing in the material to explain why the women had to do all the heavy farm work and leave their babies at home after only a two-week's postpartum layoff. Nor was there anything to explain why the men spent most of their time in complicated financial deals, swapping, bargaining and haggling, not only so that they might acquire property but also to gain the prestige and renown that goes with skill at cheating and sharp practice in their community.

What Kardiner was able to explain, working within the limits of his concept, was the inevitable result of maternal neglect on the character structure of most Alorese. They grew up into suspicious, tricky people with weak affective relationships, reminding Oberholzer of certain types of psychopaths among us. Here the value of the collaboration was most evident: Kardiner knew and presumably his collaborators did not know the untoward consequences of oral frustrations. Other points brought out through

interviews with individual Alorese were less instructive, partly due to the imperfections inherent in any such enterprise with people like the Alorese. In point of fact, Cora Du Bois's interviews with individuals among the Alorese have won the unstinting admiration of those competent to judge the difficulties of obtaining information of this kind. In addition, Kardiner's focus on character traits, particularly the pregenitally determined ones, permitted other evident traits not germane to his main discovery to recede into a scarcely mentioned background. Thus he interprets a dream of a woman asking her husband for a banana as a sign of unconscious oral longing, slurring the equally evident phallic interpretation. Early oral frustration would of course account very well for the use of a fruit as a symbol of something to be desired, but why not a round fruit instead of the husband's banana? If such a limitation is inevitably set by Kardiner's concept of the basic personality, then the concept has become a hindrance to his investigations.

Kardiner finds three aspects of his Alor work unsatisfactorily cleared up. One of these is the psychology of the women, another is the unexplained 'accepted' tradition that the women should do all the essential work even to the extent of neglecting their two-week-old babies, the third is the interminable preoccupation of the men with swapping, haggling, bargaining and cheating each other. One can nevertheless indulge in inferences or speculations that fit into other frames of reference beyond the restrictions of the basic character concept. To the naive eye, the women of Alor seem imperfectly freed slaves, compelled by custom to a life of hard labor for men. Most of the financial haggling among the men seems to relate to something called the 'bride-price', which is the sale of women. This economic subjection would tend to aggravate the women's penis envy. 'Why must we work all the time?', they might well ask, just as some women in our culture feel their sex slighted when they are excluded from gainful occupations. Apart from economic subjection, Cora Du Bois's reports on the women reveal enough to justify the inference of marked penis envy. The men's skill at cheating correspondingly represents symbolically their virility. Through purchase, as through potency, they acquire women. Further speculation would take us into the prehistory of the Alorese, and indeed suggests possibilities not inconsistent

with ideas about what happened to the women of the primal horde when the victorious brothers took over.

Alor is the second culture described in this book—in the reviewer's opinion the most interesting and best documented. The first culture in Kardiner's order of presentation is that of the Comanches, by Ralph Linton, which lacks the individual case reports of Alor or Plainville. The Comanches led a placid existence until some time in the seventeenth century when they migrated from the Montana plateau to the plains of the Texas Panhandle and southern Oklahoma. Here, acquiring horses and firearms, they changed into a loose group, devoting its best talents to war and cattle rustling. Their old religion lost its hold; their veneration of gods and respect for old men paled into disbelief and tolerant contempt. The Peace Chief was shorn of all real powers; another, young man led them on their raids. The martial virtues were exalted: strength, bravery and comradeship. Each man had his best friend, his Patroclus, whom he called 'brother', and the fraternal love of comrades was highly prized. An odd example of what went into this idea is given by Linton: a betrayed husband, even though he is prepared to kill the adulterer nevertheless must greet him as 'brother'! Sexual freedom is not only permitted but apparently in adolescence is promoted. Although the baby is strapped on to a papoose board, this has its good feature: the baby is always with the mother. Kardiner remarks on this and points out the economic advantage to the growing boy of the lack of sex restrictions. This mitigates hostility towards his parents, and the great opportunity for identification with the father works in the same direction. Aggression is turned pretty successfully against aliens in warfare. Of course the men die young, but in their peacetime moments at home they are treated like soldiers on home leave. Their young adult life compensates for the papoose board by much opportunity for motion, and for the forced passive attendance at their parents' love-making by much opportunity for sexual activity. Except for certain neurotic individuals, the 'basic character' of the Comanche brave corresponds pretty well to the demands of his cultural setting. The women seem satisfied with the rôle of sweetheart and mother.

Analytic readers interested beyond the problem of basic character will necessarily be interested in the effect of the migration on

the Comanches. The elimination of the father and father-figures, the emphasis on brotherhood, and the intermittent power of the older brother figure, the War Chief, bring to mind certain ideas of Freud as to what happened in primal hordes after the brothers took over, following the killing of the primal father. Whether the Comanches in some way really or psychologically repeated such an event before their migration is a question that doubtless never will be answered. Certain anthropologists say it should never be raised, that this brands one a member of the English evolutionary school, and analysts have been meek before this conjuration. Kluckhohn has pointed out that Freud's conceptions, as presented in Totem and Taboo, may be useful and even true, despite their basis in discredited documentation. These remarks are, however, a digression, as Kardiner makes no attempt to follow Totem and Taboo; indeed he works in quite a different field.

Plainville U.S.A. is the pseudonym of an agricultural village of two hundred seventy-five people, located in the 'central part of the United States of America'. James West not only gives an account of the economic and social life of this village in the ordinary sense but pays particular attention to the mode of child rearing, the sexual life, and to those institutions such as religion which are defenses against the crude expression of instinct. Babies are apparently nursed pretty nearly as long as they can be; older children suckle at the lactating breast occasionally at six or eight years of age. Family life is the main emotional focus and outlet. The men work in the fields and with the animals. The women cook, garden, and mother the children. The work is extensively mechanized. Money is hard to accumulate but subsistence is good. Prestige, in spite of democratic beliefs, is based on property. There are at least two classes, the prosperous river bottom farmers and the shiftless hill people. Religion has lost its hold except for the poorer people. Neurosis is prevalent, as the appended life histories show. There is naturally a good deal of sexual repression and public prudery and puritanism concerning sexual matters.

Kardiner points out the unstable features of this community. He rightly emphasizes the rôle of the mother in maintaining the social solidarity of the group; also he very clearly explains the development and function of the superego of Plainville people. Inevitably Kardiner's contribution here does not come, as it perforce did in the case of Alor, from the anthropologist's data alone.

His discussion is to a great degree on 'Western man' and on the basis of observation made elsewhere. In fact, the life histories and personality studies presented by James West are instructive just to the extent to which they are capable of interpretation in the light of extensive clinical analytic experience.

Kardiner of course assumes the presence of an œdipus complex in Plainville people. Here his analytic beliefs enable him to aid the anthropologist, for a field worker in Plainville would hardly appreciate the unconscious, even of the persons he interviewed; and it was from such data as the idealization of the mother and the correlated inhibitions on the sexual life that Kardiner was able to make his inference. Quite as reliable inferences seem to be possible concerning the Marquesans, described in Kardiner's previous book, of whom Linton says in the present book's foreword, 'Even the typical œdipus complex seemed to be lacking'. Needless to say such naive statements about unconscious mechanisms are very risky; without a telescope perhaps there are and perhaps there are not moons about Jupiter. But actually all the facts about the Marquesans are entirely compatible with their having an unconscious œdipus complex. As to the Plainville people, given the method of the survey and that alone, without Kardiner's imported psychoanalytic telescope, one would not know that the men unconsciously wanted to murder their father and marry their mother, and that they feared castration for harboring such wishes.

One manifestation of the œdipus complex passes unnoted as such in the exposition of Plainville, but comes out very beautifully in the last chapter of the book which bears the title, Basic Personality and History. Here Kardiner, in a discussion of the effect of the Reformation on 'Western man' (which seems influenced to a surprising degree by Spengler's work) notes how the Mother and the Grandmother of Jesus had been used by the Roman Catholics to mediate and intercede for the individual with the stern Father God. Plainville is Protestant when it is not atheistic, but it uses this very mechanism to protect itself against anxiety. The mother is the person who protects the child from the real or imagined aggression of the father; and much that at first sight looks like primary instinct gratification would probably analyze out as secondary and regressive eroticization of this defensive procedure. This at any rate is the common mechanism of masochism, self-subjection to the idealized woman, so long as she protects one from the father's

punishments (see Venus in Furs). As Kardiner pointed out himself in a New Republic article some years back, the lessons of *Hemmung Sympton und Angst* should caution one against accepting phenomena as directly libidinal, to the neglect of the rôle of anxiety and defense in producing them.

The last, very interesting, chapter discusses the possible alternative characters in Western man as portrayed chiefly in his religious beliefs. The chapter is too brief to do justice to this topic and there is a promise of a separate book to develop it further.

One can accept Kardiner's own feelings about his concept of the 'basic personality'. It is evidently very useful to anthropologists; it has been refined and is more accurately applied than in The Individual and His Society, yet its limitations are now much more clear and it is beginning to be restrictive. Psychoanalysis can contribute, one hopes, more than a characterology, and to more problems than are raised in this book.

B. D. L.

THE INTERPRETATION OF DREAMS. New Developments and Technique. By Wilhelm Stekel. New York: Liveright Publishing Corp., 1944. 2 vols., 618 pp.

Wilhelm Stekel died on June 27, 1940. In his lifetime, he was often blamed for his lack of organization, documentation and consistency. It would make little sense to repeat that reproach five years after his death. However, one may express astonishment that an opus from his pen announcing new ideas on dream psychology and reaching the book market so long after his decease, does not contain the author's literary remains but reprints of papers published many years ago. None of the fifteen chapters was written after 1935, many of them in 1913 and 1914. It is therefore safe to presume that the contents of this two-volume edition are known to all experts.

In a certain sense Stekel represents a tragic figure in the history of psychoanalysis. He never understood why Freud and his pupils rejected him so violently despite the fact that his name was connected with a number of psychoanalytic discoveries, particularly in the field of dream interpretation. When told that he was superficial, he replied that his books were long enough, that they would grow into libraries should he undertake to interpret dreams more

thoroughly. He did not realize that depth is a matter of quality and cannot be measured by a yardstick.

Stekel's 'intuition' which sometimes yielded extraordinary results in guessing psychic conflicts, led Freud to a comparison which, as far as I know, was never published. 'I was told', said Freud, 'that the primitives put their ears to the ground and can hear the tramping of horses many miles away. Civilized people have lost such a quick ear. They replace it, however, with telegraph and telephone which give them power to reach points far more distant. In other words we have our science and are therefore more or less independent of intuition.'

Stekel was an unsophisticated psychologist, always in good spirits, bubbling over with discoveries many of which have maintained their value up to this day. Others had to be dropped when the slow scientific methodology of psychoanalysis followed and undermined his children of intuition with its more reliable approach. They then reappeared in a different and definite shape. He came out, for instance, with the discovery that we have to consider not only bisexuality but trisexuality because in all of us there is not only the other sex but also the child. There is no question that all of us harbor an infantile component, for nothing gets lost in the psyche. The child, however, is not a third sex but a phase before a definite differentiation of the sexes takes place. Stekel fell a victim to German grammar which calls the three genders 'sexes'.

In his interpretation of dreams, Stekel relied much more on the manifest than on the latent dream; in other words, he overrated the contribution of the ego to the disadvantage of the id. Hence, he more or less rejected our association technique because, as he says, the dreamer's associations are subject to resistance just as much as the manifest edition of the dream and therefore lead the dream interpreter astray. This is true, but we presume that analysts are sufficiently armed against such resistance, their daily bread. Stekel did not believe in the phenomenon of reversal of the original meaning in secondary dream elaboration, nor do we hear of the primary function (condensation and displacement) in the book under discussion. One does not get the faintest notion from Stekel's presentation that Freud's entire theory of neuroses came from the study of the dream, that his doctrine as it later

unfolded was present as a bud in The Interpretation of Dreams of 1900.

Stekel as well as Adler and Jung, and later Rank and the other epigoni, noticed that for many years the master was busy with his most surprising discoveries concerning the id, attaining much later to the psychology of the ego. Thus for a long time these gifted pupils found green pastures, which, however, dried out under their feet when Freud came to his own study of the ego. He certainly did not reach the bottom of the problem there either, leaving for us a wide field of further investigation. Yet nobody can any longer go on with dream interpretation without keeping in mind the division of the psyche into id, ego and superego. The ego contribution to the dream is easier understood for it speaks our own language, yet is less valuable than the id contribution. When we sleep the ego is weakened and flooded by the id. Hence, the ego is better studied in our waking hours. On the other hand, when we sleep the id is partly freed of its shackles, which makes it easier for us to approach the psychology of this system. When Freud spoke of the royal road to the unconscious, he meant the road to the id.

All these are problems in which Stekel was not interested. His interpretations may be compared with the results of a man who is skilful in mental arithmetics that are often correct though he does not and probably cannot reveal how he arrived at them. Here 'intuition' stands in the place of scientific method. The weakness of intuition consists of: (1) one has to be endowed with it, (2) it may lead us astray, (3) soon a definite limit is reached beyond which there is no further progress without a scientific method. I have never met a man who could equal Freud in intuition, i.e., of inexplicable immediate psychological insight. But he also had scientific self-control which—with a few exceptions—did not trust his unproved visions.

After considering all these limitations, let us now enumerate the main points of the system which Stekel recommends. He begins with a simplification of the dream, advising us to think in 'headlines' similar to those of newspapers. To do that, one needs a certain experience and practice in order to separate the essential from the nonessential parts. This is followed by what he calls the 'reduction to the basic affect' such as astonishment, impatience,

joyful expectations, fear, etc. Then he looks for antitheses and polarities such as up and down, active and passive, libertinism vs. puritanism. He pays attention to repetition in dreams, tries to understand the allegoric presentation of the present-time conflict, the dream's relation to the analytic situation and the symbolism of death and birth. He emphasizes the relation of the dream to hidden religious and criminal tendencies, of whose discovery Stekel was particularly proud. Without deducting from the practical importance of these tendencies, we realize that both of them are but individual cases of the powers of the superego and the id. Stekel follows the dream's homo- and heterosexual lines and also the infantile component. He describes three chief trends in dreams: the present-day conflict, the root leading way back (retrospective trend) and the look into the future (prospective trend).

In order to be able to find all this in a dream, we must—says Stekel—have a knowledge of the dreamer's personality and of his life history; we have to guess his central idea which is often carefully hidden, and we must also know his mental conflict. We have to watch the patient's specific reactions while telling a dream and also to our interpretation, whether he remains indifferent or, perhaps, rejects it violently. Series of dreams often facilitate 'intuitive' interpretation. They can be read like a novel in continuations. Stekel asks himself, 'How would I myself think and feel were I in the patient's situation?'. To achieve a trustworthy solution, the analyst must be free of blind spots. In other words, he must be analyzed himself. There might also be the danger of introducing his own 'overcharged' (supervalent) pet ideas into the dream which he analyzes.

Stekel took great pains with dreams and was very successful with them. His book contains three hundred and sixty-two dream examples and much can be learned from it. Even if we feel that we knew most of what he presents, he refreshes our memory. Why, e.g., do we often dream of people for whom we don't care in the least, of whom we have not thought in years? Because they have qualities which the dream wishes to introduce in its pictorial way. What is the meaning of strange figures of which we cannot rid ourselves such as maid servants living in the family for a long time, alter egos, museums or parts of them? They symbolize the neurosis with which one is so familiar.

We find in Stekel's book not so much new ways of dream inter-

pretation as good old acquaintances, some of whom we have perhaps forgotten but whom we greet in a friendly manner because they are welcome to our daily clinical work. Maybe we have also forgotten that many a symbol which today seems to be quite obvious was discovered by Stekel almost forty years ago. Stekel met Freud in 1898, in that heroic time, when under Prospero's magic wand the earth day by day threw up new discoveries. The master himself stood in the center of the ring but all those around him came home with shiny findings. In those days, Stekel was one of his most successful disciples; later the two had to sever because one of them became more and more strict in his scientific methodology while the other continued with hardly any methodology at all.

FRITZ WITTELS (NEW YORK)

THE SHAPING OF PSYCHIATRY BY WAR. By John Rawlings Rees, M.D. New York: W. W. Norton & Co., Inc., 1945. 158 pp.

The Salmon Lectures, delivered by the consulting psychiatrist to the British Army and Medical Director of the Tavistock Clinic, compose this volume. The author's extensive experience with psychiatry during World War I as well as in World War II makes it the expression of mellowed observation and judgment.

The book really consists of a series of brief essays on a great variety of topics, which represent the innumerable links of psychiatry to the problems of military and social life in almost all their aspects. This diversity makes it impossible to present an adequate summary of the book. It deals with all the activities of a psychiatrist in the services. The author points out that 'the friendly running fight against opposition' is, of itself, stimulating, and that, 'for most psychiatrists army service provides a new angle to their job and the art of psychiatry itself becomes dynamic'.

As to treatment, the author is not yet sure whether methods have developed very much. In spite of the use of sedation, narcoanalysis, and modified insulin therapy, returns to duty are no greater than during the last war, although possibly long term results may be better.

The author points out the need for recognizing the dull man with a low I.Q. and assigning him to appropriate duties. He emphasizes the necessity for giving as much attention to the mental as to the physical health of the potential officer. An excellent series of points on leadership and morale is included. It is pointed out

that disciplinary action should not be resorted to without investigation of the failure in morale which underlay the behavior. Without morale, discipline can never really be good.

The need for the study of personality is stressed. 'The total annual cost of the comprehensive psychiatric services of the British Army equals the cost of the British contribution to running the war for an hour and twenty minutes'.

Among the manifold topics in this slender volume is the treatment of Japan and Germany. Whether we treat them 'kindly or roughly' is as irrelevant as whether we treat the individual neurotic in either of these ways. What matters is that we should understand the people, their make-up and their social setting, and that we shall devise methods by which these can be modified to the advantage of the world as well as to themselves.

Although much in this book will be familiar to the military psychiatrist, the observations are keen and penetrating. It will provide the civilian psychiatrist with a little of the atmosphere of psychiatry in the service.

LEON J. SAUL (SWARTHMORE, PA.)

PERSONALITY AND THE BEHAVIOR DISORDERS. Edited by J. McV. Hunt. New York: The Ronald Press Co., 1944. Vol. I, 618 pp. Vol. II, 624 pp.

This book is an encyclopedia of present-day psychology in all its branches, including those of medical psychology. 'Personality' is conceived as a not sharply delimited field, and almost everything that bears on it is considered proper content for this book. 'Straight' brain anatomy and much of brain physiology is omitted; nor is there any attempt to put the subject in a historical perspective. The authors of the separate chapters have been selected because of unquestioned competence in their special subject. Professors MacKinnon, Guthrie, Mowrer and Kluckhohn set forth general theoretical approaches to personality. The tests and 'cross-section' methods used by experimentalists and personnel psychologists are discussed by Edward S. Jones, J. R. Maller and Robert W. White, while the dynamics of behavior, experimental behavior disorders, and hypnotism are discussed by Thomas M. French, Leon J. Saul, Robert R. Sears, Kurt Lewin and his collaborators, Saul Rosenzweig, H. S. Liddell, Frank W. Finger, Neal E. Miller and Arthur Jennings. Heredity, constitution, brain lesions, and physiological

factors are treated respectively by L. S. Penrose, William H. Sheldon, Stanley Cobb and Nathan W. Shock.

Determinants of personality (experiential and sociological) are set forth by Margarete A. Ribble (infantile experiences), Lois B. Murphy (childhood experiences), Phyllis Blanchard (adolescent experiences), Gregory Bateson (cultural determinants) and Robert E. L. Faris (ecological factors). Leo Kanner writes of behavior disorders in childhood, Lawson G. Lowrey of delinquent and criminal personalities. A. Warren Stearns describes personalities unfit for military service. W. Malamud, Norman Cameron, P. W. Preu and W. G. Lennox deal respectively with psychoneuroses, functional psychoses, psychopathic personalities, and seizure states. J. McV. Hunt has a chapter on psychological deficit, and Donald B. Lindsley on electroencephalography. Psychiatric therapy is treated in a long chapter by Kenneth E. Appel, and the prevention of personality disorders by George S. Stevenson.

This list of subjects and authors would without question win the approval of most workers in the fields covered; and where the authors stick to their own fields their expertness is immediately evident. Thus French gives an excellent summary of psychoanalytic views of dynamics, Saul enriches the literature not only with an exemplary exposition of his subject but with a nearly perfect bibliography as well. Comparable credit is due Liddell, Cobb, Ribble and most of the other authors.

However, some of the authors stray from their garden to pick a little something from an alien field, and then there is occasionally an unhappy sentence or two. Thus one author cites Emil Ludwig's theory that the ex-Kaiser's withered arm determined his personality, without mentioning Freud's objection, which was to the effect that this was trivial in comparison with the fact that his mother did not love him. Another author says, 'Brunswick presented interpretations of the dreams of a paranoid woman, but her analysis shows considerable internal evidence of indoctrination by the therapist'. This sentence shows internal evidence of indoctrination by a similar statement of Mayer-Gross in Bumke's *Handbuch*—an alien weed of an opinion that might just as well not have been transplanted. Nor is much lucidity to be derived from some conscientious expositions of Freud's views. From this criticism I specifically except Bateson and Sears; I include Guthrie and Kanner.

But these are small matters in the framework of Hunt's scheme, and the books can be recommended to critical readers.

B. D. L.

EMOTIONAL FACTORS IN LEARNING. By Lois Barclay Murphy and Henry Ladd. Sarah Lawrence College Publications, No. 4. New York: Columbia University Press, 1944. 404 pp.

Those who conceive of individual education as catering to the whims and fancies of the student should read this book. It is a realistic clinical account of the actual complexities encountered when a college seriously accepts the proposition that young women require an education in which their interests and needs are discovered and served, if they are to be 'so taught as to live as abundantly as possible—that is, achieve the emotional and intellectual maturity that will make possible the fullest and wisest participation in the contemporary world' (p. 6.). At a time when this country is taking the lead in breaking from authoritarian modes, such reports of pioneering effort are especially relevant. And the psychiatrist will prick up his ears upon hearing: 'When emotional factors in learning are seen to be important not only in problem cases but also in a large proportion—if not all—of the student body, guidance becomes a preoccupation of every day. . . .' (p. 9). Here is our potential clientele; what is a modern college doing to foster emotional maturity and capacity for successful motherhood?

The first part of the book is not strictly in the field of psychiatry. It discusses the functions of educational diagnosis and advice, how to evaluate 'interests' and motivation, how to deal with different learning attitudes, and so on. Beginning with the chapter on Patterns of Personality, it becomes a psychiatric study. A careful survey and follow-through of one entire class disclosed, to be sure, that about half of these girls maintained a relatively unimpeded educational progress: they were integrated persons, ready to go ahead. Individualized education meant for them the exploring of interests, finding of needs, helping with special lacks, and facilitating appropriate projects. It was the other half that the faculty worried about: the ones for whom individualized education meant diagnosis and efforts to remove educational blocks. By no means were these students to be dismissed as intellectually inadequate. The descriptive diagnostic categories include rigid students, scat-

tered students, spasmodic workers, perfectionists, the superficial, and the egocentric. In all these cases it was clear that their problems in college stemmed from their own characters and represented attitudes which pervaded all aspects of their life. About half of this group showed definite symptoms. They were described by teachers as shy, anxious, worried, insecure, afraid to explore new areas, or as having an unusual number of fears. The remainder seemed to have developed defenses, compulsive methods or façades—character armor which concealed anxiety but warped educational growth.

The second half of the book presents eleven case studies of such problematic students. The presentation is fascinating and stimulating, and the casual reader is advised to commence at this point. One is struck by the persistence with which the faculty, while recognizing the student's 'basic self' as the problem, attempted to modify the anxious and conflict-laden character structure through tangential approaches—hoping to encourage her to an area of security through successful performance here, to loosen her into spontaneity there, or to assist her in objectifying her family situation by projects in psychology and anthropology. Often the disturbed 'basic self' was treated as destiny and the student was helped to build further defenses for it. In none of these cases, apparently, was a specifically psychotherapeutic approach recommended. In nearly all of them some progress was recorded, but in scarcely one was there an approximation to the self-understanding and integration vital to emotional maturity. Lois Murphy comments at the close on the many insecurity-creating factors in the backgrounds of these girls—most of them from a leisure-class culture—and remarks gloomily, 'College spends four years trying to correct, too late, traits of temperament which should never have been formed' (p. 391).

The psychoanalyst, however, will feel that not every stone has been turned, even though he would praise the fine educational-therapeutic work which was done. These troubled girls were clearly 'lived by unconscious forces' which seriously limited all methods of working from the surface and made some degree of analysis obligatory.

Why was not a thoroughly dynamic psychology utilized? Could it be that when these studies were being made—more than five years ago—psychoanalysts were not achieving success in such character analyses nor describing processes with enough clarity to arouse the

confidence of educators? If so, can we now meet the challenge? Could it be that the majority of such students shrink from a direct approach to their underlying problems? Actually a fair number of these eleven girls either asked outright for help in understanding themselves, or indicated by confiding their emotional turmoil that they would welcome help. The reviewer, in rapidly checking a list of recent upperclassmen in a similar college, finds that of the more than half who seemed to show 'basic self' difficulties in their educational career, some forty percent have sought psychiatric counsel. Evidently the taboo can be lifted.

Or could it be that the faculty were unduly hesitant, frightened of being accused of amateur psychiatry, unsure in the use of new insights? Ruth Munroe affirms this in a cogent discussion at the close of her companion book in this series (Teaching the Individual Student) and remarks, 'Old-fashioned academic discipline is as definitely "psychiatric" an approach as any of our more self-conscious departures'. Evidently the task is inescapable, the potential contribution to both preventive mental hygiene and constructive education is incalculable—and we have much to learn!

JOSEPH CHASSELL (BENNINGTON, VT.)

DOLL PLAY OF PILAGÁ INDIAN CHILDREN. By Jules and Zunia Henry. New York: American Orthopsychiatric Association, Research Monographs No. 4. 1944. 133 pp.

This is the best and most extensive field work done on any group of children in a primitive society.

The authors summarize their conclusions as follows:

> 'The study of Pilagá intrafamilial relationships shows that under similar conditions of familial tension children in distinct cultures will develop the same kind of symptom patterns.
>
> 'The study of Pilagá children shows also that the patterns of behavior in sibling rivalry among them follow with little difference those found in our own society. The most important difference between the sibling rivalry patterns in our society and those found among the Pilagá is that among the Pilagá remorse and self-punishment do not occur as the consequences of hostility. Inasmuch, however, as remorse and self-punishment, while outstanding as general cultural sanctions in our own culture do not occur in Pilagá culture at all it must be concluded that the difference in the sibling rivalry pattern between the two cultures is culturally determined' (p. 80).

I do not know whether the authors intend to convey such a significance but at any rate it is easy to see that this statement might be interpreted as meaning that the mechanism of turning against the ego is absent. However let us see what happens in the play hour of Tapangi, age between eight and nine, female, with a younger brother, age four and a baby brother, age fifteen months.

> 'She says, "Shall I make a vulva? Oh, here is one". Puts baby doll to nurse, its mouth to breast of mother doll. Puts self doll next to baby doll and brother doll on the other side. Puts brother doll on the same side and self doll farther away. Bites self doll with turtle (1), turtle now bites mother (2), self (3), baby (4), brother (5). Turtle bites self doll over and over again' (p. 89, 90).

This and similar instances make it perfectly clear that the turning against the ego is an intrinsic part of the sibling rivalry situation. I do not quite see why the play situation should be focused on sibling rivalry, but in whatever the authors are interested or want the children to act, the œdipus complex breaks through. An excerpt from the introduction by David M. Levy shows this quite clearly:

> 'The next day in his play with dolls, he placed the sister doll and the one which had been given his own name at the breast. On the third occasion he shook his fist at the sister doll and said "stop it". This he repeated and then made sucking noises over the mother doll's head. He then shook his fist at the mother doll. This was followed by putting the doll representing himself between the legs of the mother doll, saying "They are having intercourse" (p. XI). Then what did he do with the sister doll? He cuts her vagina out, then her belly. Then he cuts the throat of the doll that represents himself, and then he cuts the doll's penis and says, "I cut off my penis" ' (p. XI).

In spite of all this the authors keep saying that self-punishment does not occur in their data (p. 20). Do they perhaps regard self-castration as a reward?

The term œdipus complex does not occur in the book but there is plenty of it in the actual data:

> Yorodaikolik, age four, plays as follows: 'Puts mother doll, face down, on top of all the dolls and says: "Look, she is having intercourse". Lays doll down on its back and places self doll on top of mother doll in copulating position' (p. 92). Deniki, a boy of fifteen months, 'puts self doll and then sister doll on mother doll. Mother doll is lying on its back, self doll is lying on it, face down. Deniki crows delightedly. He picks up sister doll and puts his finger on the vulva. Picks up sister

doll and tries to separate legs.' (p. 97) Another boy, age six, 'makes penises for the dolls. Makes the largest penis for the self doll. Puts self doll next to mother doll, father doll on the other side of self doll' (p. 101).

In the interpretations the authors consistently underemphasize œdipal situations in spite of their abundant affirmative material. Nevertheless it is evident that the authors have made a very important contribution to psychoanalytic anthropology.

GÉZA RÓHEIM (NEW YORK)

THE UNKNOWN MURDERER. By Theodor Reik. New York: Prentice-Hall, Inc., 1945. 260 pp.

In this book Reik advances the thesis that the idea of a trial for the purpose of ascertaining the perpetrator of a crime and the manner of its commission is a comparatively late development in law. Originally, in prehistory, crime was simply the breaking of a taboo and was detected by the inevitable effect of the transgression: whoever fell ill or had a mishap (that is, whoever was 'punished') was the guilty one. The author attempts to demonstrate that our modern criminological and penal practices show many vestiges of ideas that have survived from the primitive, animistic stages of culture and that some of our most scientific means of crime detection still show traces of their prelogical origin. According to Reik, moreover, our current legal machinery leaves far too much room for the operation of irrational, unconscious factors in the judicial process. Illustrations are given of fantasied omnipotence of thought in both prisoner and prosecutor, of the narcissism of judge and jury, of the deep unconscious background of many legal errors. (One cannot help feeling that the law would do well to develop conscious insight into these trends instead of attempting to deal with them in terms of almost blind reaction-formations as exemplified in the judicial philosophies of men like Cardozo and Holmes.)

This volume is textually identical with the Hogarth Press edition of 1936. It is well written and well translated from the German by Dr. Katherine Jones and, despite the evident background of painstaking scholarship, sufficiently diverting to maintain the flavor of light reading. The inclusion of the gist of several good murder mysteries may add considerable zest for many readers.

JULE EISENBUD (NEW YORK)

REBEL WITHOUT A CAUSE. The Hypnoanalysis of a Criminal Psychopath. By Robert H. Lindner, Ph.D. New York: Grune and Stratton, Inc., 1944. 296 pp.

This is another book dealing with a delinquent, in this instance one who is in a penitentiary—for what and for how long it is not apparent. The author states that the patient's somatic complaints cleared up during forty-six hours of treatment, treatment which he calls hypnoanalysis and describes as a combination of hypnosis and psychoanalysis. During the first thirty-eight sessions the patient is supposed to have associated freely. Only in the last eight hours is hypnosis employed—to bring certain memories and other material to consciousness. To the author's satisfaction, the patient recovers a memory which he says belongs to a period when the patient was between six and nine months of age.

Lindner is a psychologist. In a discussion of psychopathy he says many questionable things and makes many invalid generalizations. In discussing psychoanalysis, particularly in relation to criminality, he attributes concepts to psychoanalysis which are not a part of clinical psychoanalytic thinking. There is a vast psychoanalytic literature on delinquency to which but little reference is made.

The story presented in this book is duplicated in many of the excellent reports of social workers in the child guidance field. It represents a valiant effort but does not present any unique result. The success of Lindner's treatment notwithstanding, the concepts and formulation of the method do not represent the new development or departure claimed by him. Then, too, one must remember that in psychotherapy with inmates of a penal institution the positive transference or compliant attitude, when at all present, is usually very strong, while the negative aspects of the transference are much less likely to appear because of the inhibiting factors inherent in the incarceration. It might further be remarked that the use of hypnosis under such conditions renders the already more or less compliant patient even more suggestible, and sometimes what one unconsciously wishes to obtain from him may thus be obtained quite readily.

In his summary the author makes rather extravagant and unwarranted claims for his discovery. He states that 'for the first time, we have been privileged to penetrate beneath the armor which persons of such classification present to the world, and to view

in all their sinister automaticity the operationism of the responsible mechanism', and adds, 'In a word, it [the author's method of treatment] verifies the major but until now unproven hypothesis of the traditional psychoanalytical view of this entity [the unresolved œdipus situation]'. Finally, he says, 'In short, hypnoanalysis is a radically abbreviated method for the investigation of the personality and treatment of psychological disorders and aberrations of behavior'.

There is a bibliography but it does not do justice to the wealth of material psychoanalysis has contributed to the store of knowledge about delinquency. I. T. BROADWIN (NEW YORK)

WOMEN AND MEN. By Amram Scheinfeld. New York: Harcourt, Brace & Company, 1944. 453 pp.

Amram Scheinfeld, the author of a very successful book, You and Heredity, has undertaken the challenging task of writing about such an old, controversial question as the differences between the sexes. The result is very interesting and readable and contains many informative tables and amusing drawings by the author. In the course of his courageous enterprise he soon found himself caught between biology and sociology. He writes in the preface, 'The most significant fact about this book, I believe, is that it isn't what it started out to be'. Originally he intended to devote himself mainly to social factors as the decisive influence in shaping the character traits of men and women and 'to give only passing attention to biological sex differences'. But in the course of his laborious work he felt himself compelled to depart from 'the prevailing tendency among social scientists to regard differences between women and men in behavior, thought, temperament, and achievement, as chiefly the products of "conditioning" '. These 'current theories' began to appear to him very questionable.

Scheinfeld follows egg and sperm from beginning to end in all their phases—physical, physiological and psychological. He bases his work on the investigations of numerous specialists in biology and sociology. Out of the wealth of the interesting, occasionally startling material that the author compiles and discusses, only a few examples can be mentioned here.

Probably one hundred twenty males to one hundred females are conceived, whereas the ratio at birth is only one hundred five or six males to one hundred females, so much higher is the prenatal mortality of the male. Sex-linked heredity factors account

for the fact that boys are weaker in resistance than girls. Likewise the death rate in the first year of life is twenty-seven per cent higher in boys. There are some basic sex differences in muscular coördination in children, girls being superior in finer motor coördination. Observations in apes show similar pictures, the female ape child being more sedentary and less destructive, more sociable, more fond of bright colors. Scheinfeld calls attention to the fact that girls become biologically mature earlier than boys. This should influence the concept of coeducation where children are taught together in accordance with their chronological age rather than their biological one.

To what extent are character traits influenced by nature and to what extent by social conditioning? Scheinfeld comes to the conclusion that basic instinctual drives develop and favor different character traits: in the male aggressiveness and initiative, warring and hunting being more natural for the man, while the functions of motherhood lead to different traits in the female. Margaret Mead's findings of isolated primitive tribes with a reversed pattern of behavior are explained as rare exceptions, probably artificially conditioned. Character traits themselves, although based on natural differences, influence the attitude of society and the upbringing of children so that the result is caused by the interaction of biological and social factors.

An interesting item is the table of suicides showing that suicides occur more than three times as often in men as in women. This in Scheinfeld's opinion shows that women have a 'better psychological shock absorber'. Our explanation would be that this is a confirmation of the basically greater aggressiveness in men.

Scheinfeld discusses such diverse topics as crime, clothing, division of labor and aptitudes for different types of work. According to the most competent observers chivalry of the male toward the female is not a development of civilization but is originated by nature: 'there is a deep-rooted instinct which at all times inhibits in the male any impulse to fight with a female of his own kind'. When, if ever, males fight females of the same species, the female is generally the aggressor.

The merit of statistical investigation is shown in certain problems of present-day marriage. One girl in seven must of necessity remain unmarried, because of the shortage of men which began before the war and will be increased by the casualties. While in 1930 the excess of males in the United States of America was one

million one hundred twenty-five thousand, by January 1, 1944, the excess of females was three hundred thirty-one thousand. Scheinfeld points to the fact that this means a threat to our system of monogamy which he thinks is less founded on religion or morals than on the one-to-one sex ratio provided by nature.

Scheinfeld's task would have been much easier, had he had a deeper knowledge of analytical genetic psychology. He neglects the whole body of psychoanalysis when he writes that 'the prevailing attitude among sociologists and psychologists is that instincts are either not at all operative in human behavior, or else are completely submerged by social influences'. Freud's epigram 'Anatomy is destiny' would have been very helpful to him.

In addition to its valuable factual material and its intelligent and careful discussions of controversial issues, Scheinfeld's book has a certain documentary value in the struggle within the author himself that runs through the whole book—so hard must he fight for age-old knowledge that men differ from women. This book, which gives the reader new details or refreshes old medical learning, offers after all a knowledge that mankind has always possessed. It restates—and that is its main value and its importance—basic experiences that were lost by many under the influence of social theories in the last decades. These theories, seemingly scientific, prove to be nothing but another defense against the threat of the instincts. Even some psychoanalytic groups, influenced by this trend, overstress social and psychological factors. Psychosomatic research must be carefully guarded against this tendency. The same defense which once denied the unconscious now easily leads to the denial of the biological basis of man and of the forces of nature.

Freud once wrote that mankind, through psychoanalysis, experienced a 'psychological humiliation' of its pride. Now, with the help of psychology and social conditioning, it longs again to be master in its own house—so ineradicable is the wish to regain the omnipotence of infancy.

To add a little humor to a serious problem, Scheinfeld quotes from a widely read and influential book by a German couple, Professor M. and M. Vaerting, published 1923, in which even the physical sex characteristics were attributed to conditioning, to be 'merely the characters of the subordinate sex under monosexual dominance' which would 'disappear slowly but surely when equality of rights is established'. They look triumphantly at the United

States where this development was 'already so marked by the year 1910 that voices were raised in warning . . . that within a few years American women would no longer be distinguishable from men'.

In spite of everything, it is hardly understandable why people are so eager to deny the sex differences instead of making the best of them.

HENRY LOWENFELD (NEW YORK)

MUST MEN HATE? By Sigmund Livingston. New York and London: Harper & Brothers, 1944. 344 pp.

Although one might not expect it from the title, this book is a discussion of anti-Semitism. It is a dignified, scholarly, dispassionate statement by the founder and chairman of the Anti-Defamation League. It is not primarily a psychological or sociological study of hate: the bulk of the book is devoted to factual statements concerning various anti-Semitic occurrences and accusations. This method is based on the author's belief that the long-term solution of the problem is through a recognition of the truth. As he sees it, anti-Semitism is not based upon reason at all, but is emotional in origin. It is of course consciously utilized and exploited for political power, economic aggression, personal aggrandizement, and so on, but it is itself 'an expression of hatred the seeds of which were planted in the days of childhood, when the mind is subtly conditioned for the reception of libels and fictions. But it is without definable end, without purpose, and without objective.' The author describes how some of the seeds are planted, from verbal references in early childhood by well-meaning parents, through The Merchant of Venice in school reading, to the full political anti-Semitism of adults. This part of the book comprises the first one hundred twenty-nine pages.

Most interesting from the psychological point of view is the comparison of anti-Semitism with witchcraft. Like witchcraft, says the author, anti-Semitism arises from the emotions and is a form of delusion. What is hated is an imaginary Jew who no more exists than did the witches, and as with witchcraft, the only long-term treatment is to combat the delusion with reality. 'Many deep-seated delusions, once universally believed, have been eradicated. Among these were . . . the belief that slavery was instituted by divine will; the sacrifice of humans and beasts, and many other firmly established convictions which have been expelled from the mass mind by a slow process. . . . One hundred leaders

of progressive thought in America, properly organized and backed by the churches and the newspapers, could destroy this monster and render a lasting service to our country and to humanity at large.'

Buoyed by such optimism, Livingston's chief effort is to attack delusions and trumped-up charges with facts—and his facts are interesting. He includes an extensive review of the contributions of Jews to civilization and to the present war effort. He recounts facts concerning the Dreyfus affair, the rôle of Jews in the discovery and settling of America, the early persecution of Catholics in this country and so on. He shows that exactly the same accusations that have been made against the Jews were made against the early Christians by the Romans and against many other persecuted groups: Huguenots, Quakers, Puritans, Mormons, Catholics and others. He believes that this hate, which underlies all intolerance, originates in frustration but he does not carry the analysis of it further, since his thesis deals only with this form of it. It is certainly easier to be optimistic about attacking a delusion than about reducing man's hostility, though this too is by no means impossible.

The psychiatrist cannot but be stimulated to reflect once again upon how easy it is to overestimate the reasonableness of man and to fail to appreciate how delusional is his thinking, how remote from reality it quickly becomes as soon as his emotions are touched. He will see again how easy it is to comprehend even the most complex machine, as compared with grasping the reality of human problems. The reader of this book will enjoy contact with a fine attitude and will learn something about the effects of hate, if not about its sources. LEON J. SAUL (CHICAGO)

WHAT IS HYPNOSIS: Studies in Conditioning. By Andrew Salter. New York: Richard R. Smith, 1944. 88 pp.

Salter doubts whether a science of psychology is possible when human behavior is 'so complex that many approaches to it take refuge in deviations from naturalism' and 'when its psychotherapy fails more often than not—in short, neither predicts nor controls but simply does not work'. In practically the very next breath, however, he claims that hypnosis, although the most unnaturalistic aspect of psychology, is its 'most scientific segment'. The fact that further reading yields largely quotations of already well-known concepts of hypnosis but nothing new to clarify any of its prob-

lems, serves further to alienate the psychologically oriented reader. Salter's contribution seems principally to be an animated enthusiasm for his subject, couched in lavish and grandiloquent language.

To Salter, hypnosis—which is 'all-conditioning'—becomes 'an instrument of the most fantastic power and the person under treatment needs neither faith, nor hope, nor confidence for satisfactory psychotherapy'. This viewpoint, which discards the accepted basic concepts of hypnosis—suggestion and rapport—is very often contradicted by the author, since he frequently avails himself of the 'suggestion' when speaking of posthypnotic phenomena. As for the 'rapport', he openly concedes that 'it is grafted on the subject in the early stages of teaching autohypnosis'. Incidentally, the autohypnosis, so highly praised by the author, as a psychotherapeutic method, which appears to be the core of his originality, seems very limited in its possibilities. He himself admits that only one out of five can acquire the technique.

There is throughout the book a tendency towards oversimplification of clinical phenomena, sometimes bordering on naiveté. For the author, even the criterion of a well adjusted personality seems to be a matter of simple definition, to wit: Case 47, concerning a young woman of twenty-two, who gave an impression of alertness and mental stability—the latter verified after the seventh session by a Bernreuter Personality Test—was found to be 'less neurotic than 95 per cent of the adult female population, slightly above average in self-sufficiency (57.2 per cent) and more extroverted than 90 per cent of women. She was more dominant than 95.2 per cent of women and her high dominance score, which her behavior verified, had no effect on her hypnotizability. She was distinctly self-confident and sociable—more so than 92 per cent of women. Here, then, was a well-adjusted personality'.

This is quite clearly not a book for the student who seeks a scientific approach to hypnotism. PAUL FRIEDMAN (NEW YORK)

THE IRON GATES. By Margaret Millar. New York: Random House, 1945. 241 pp.

This is a not unusual mystery, reaching the distinction of being reviewed in these pages because the murderer finds her tortuous way to a sanatorium. The author has an interesting conception of how a person 'goes mad' which adds spice to an otherwise routine killing. It can be recommended to detective story readers but it offers no new insight into mental illness.

MARGARET N. STONE (NEW YORK)

ABSTRACTS

A Clinical Contribution to the Psychopathology of the War Neuroses. Elizabeth Rosenberg. Int. J. Psa., XXIV, 1943, pp. 32–41.

Mrs. Rosenberg studied three cases of rather severe neurotic episodes—one after an air attack, two after Dunkirk—in soldiers with previous good mental health. In all three cases it transpired that in spite of the healthy pre-morbid personality, the precipitating traumata had mobilized old unconscious conflicts. The nature of these conflicts was very different in these three cases. In the first case a severe œdipus conflict was reactivated. The second 'had reacted with guilt and anxiety after the release of formerly repressed aggressive and sadistic impulses'; the third 'presented depressive symptoms following experiences which appear to have approximated to a repetition of some primal traumatic situation'.

These observations are used to discuss some theoretical questions. The author stresses (1) that there is no cause to believe that war neurotics are 'weaklings trying to evade duty and return home'; (2) that the diagnosis 'anxiety state' is of no dynamic value whatsoever, since anxiety may occur in neuroses of very different psychological structure; (3) that the release of aggressive impulses in war may be responded to by the reactivation of various conflicts and pathological reactions; (4) that depressions in the clinical picture of war neuroses are due to the internalization of aggressive impulses.

OTTO FENICHEL

Cautionary Tales. Ella Freeman Sharpe. Int. J. Psa., XXIV, 1943, pp. 41–45.

Educators since ancient times have made use of 'cautionary tales': 'If you play with matches, you are going to burn yourself'. Mrs. Sharpe stresses the point that 'dangerous' instinctual impulses in this respect are treated in the same way as external dangers by educators as well as by children. Several patients understood and used cautions against fire as cautions against masturbation. However, one finds it difficult to follow the author when she calls the idea that mother might have been robbed of her penis by father's sexual attacks, or the fantasy of dreadful subterranean dragons, 'cautionary tales' produced in order to help the ego to fight off incestuous demands. These ideas seem to be the motives of repression of incestuous demands rather than methodical aids of the repression.

OTTO FENICHEL

The Idea of a Change of Sex in Women. S. H. Foulkes. Int. J. Psa., XXIV, 1943, pp. 53–56.

Every psychoanalyst has met fantasies of a change of sex in women and knows that these fantasies are frequently connected with anxiety and guilt feelings so that they become either repressed or appear as terrible threats rather than as things to be longed for. Girls frequently try to escape from the conflicts between the tendencies, 'I want to be a man' and 'I am afraid of becoming a man' by ideas of introjection: 'If I have a penis within me, or if I become

a penis myself, I do not need to be afraid of the violence of my wishes in that direction any more'.[1] This escape occasionally fails, and the girl becomes afraid of her introjection ideas.

Foulkes describes the same material, but interprets it somewhat differently. For him, the introjective idea is not a result of a wish to become a man, but the idea of a change of sex is rather a result of a preceding and threatening introjective fantasy: 'The patients considered themselves possessed by a male principle, a man, or more concretely speaking, a penis inside themselves. . . . The frightening element in the threatening change of sex lay precisely in the fact that these fantasy organs had thus to be revealed, to come out into the open and be set free.'

Four reported case histories are not convincing evidence for such a primary introjective fantasy. The first patient is a paranoid schizophrenic with the delusional idea that a sex changing operation will be performed on her; the second is 'a typical hysteria, for whom the change of sex was a horrible idea'; the third patient was governed by fear of loss of control, which meant a fear of her own aggressive tendencies, and according to Foulkes, was due to the activity of 'a man inside herself, who might get the better of her and break out of her'; the last case was suffering from latent homosexuality, and dreamed that she was chasing a man who turned out to be a woman.

OTTO FENICHEL

An Individual Point of View on Shock Therapy. A. Cyril Wilson. Int. J. Psa., XXIV, 1943, pp. 59–61.

Wilson is not only in favor of using methodical psychotherapy after the completion of shock therapy, but also stresses the necessity of observing and using mental dynamics during shock therapy. Of special importance is the transference significance of everything which doctors and nurses do. 'The physician assumes the rôle, for the time being, both of liberator and persecutor. . . . It is for this reason that the encouragement of the transference, both positive and negative, should play an all-important part.' Wilson hopes that if this is taken into account relapses after shock therapy will be less likely to occur.

OTTO FENICHEL

The Principles and Methods of the Training of Child Psychoanalysts. Sylvia M. Payne. Int. J. Psa., XXIV, 1943, pp. 61–64.

This is a report of the principles and methods of the training of child psychoanalysts used at the London Institute of Psychoanalysis, read before a Joint Meeting of the Educational and Medical Sections of the British Psychological Society. In general, the principles and methods are the same as those used in the United States, but there are a few differences worth mentioning.

The London Institute recognizes 'that a medical degree is not necessarily essential for the practice of psychoanalysis'. However, 'non-medical candidates must have a university degree or its equivalent, and have had some special experience which makes them suitable. Some scientific training is regarded

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[1] *Cf.* Fenichel, Otto: *Die symbolische Gleichung Mädchen = Phallus.* Int. Ztschr. f. Psa., XXII, 1936.

as particularly valuable.' The London analysts believe that 'children under five are, generally speaking, easiest to analyze'. The regulations concerning training analysis, theoretical training in lectures and seminars, and supervised work, do not differ from American ones. Finally, the author stresses the importance of child psychoanalysis for mental hygiene and for education in general.

OTTO FENICHEL

The Tree of Life. Ernest Rappaport. Psa. Rev., XXX, 1943, pp. 263–272.

The usual interpretation of the tree in the Garden of Eden is that it has a phallic significance. More correctly, the tree signifies the mother and the fruit represents her breasts and vulva which the father denies the son. The serpent is Adam's penis with which he beguiles Eve. Many myths are considered, all of which show that the tree is a maternal symbol. The subtitle of the article, A Psychoanalytic Investigation of the Origin of Mankind, is a little pretentious.

EMANUEL KLEIN

On Spelling. Richard Sterba. Psa. Rev., XXX, 1943, pp. 273–276.

While our conscious minds are meticulous about correct spelling, our unconscious minds completely ignore it. The sound of the word conveys the meaning. Dream distortion makes frequent use of this fact, the manifest dream alluding to a hidden object by means of another object with the same name, or a name of similar pronunciation with different spelling. This utilization of spelling distortion is seen in many dreams, among others in dreams of psychoanalytic patients who try to conceal a latent negative transference.

IRENE JOSSELYN

Infantile Sources of Artistic Interests in the Neurosis of Marie Bashkirtseff. Erwin O. Christensen. Psa. Rev., XXX, 1943, pp. 277–312.

Christensen tries to demonstrate that Alice Hermann-Cnizer's assumption that Marie Bashkirtseff's drawing ability is based on an early hand libido is insufficiently supported by the artist's 'Journal', which mentions the importance of the hand chiefly in adolescence, not in early childhood memories.

According to Christensen, Marie Bashkirtseff's painting represents an outlet for many different instinctual drives, among which he finds sadistic and masochistic tendencies, strong narcissism, penis envy, and mother attachment.

RICHARD STERBA

On Relations Between the Ego and the Superego. Gustav Bychowski. Psa. Rev., XXX, 1943, pp. 313–325.

The author states that the superego may be 'retroprojected' on persons in adult life, and that in this way ancient conflicts may be repeated. Many clinical observations are cited which show how new people in the environment take on the characteristics of superego images. The various attitudes of the ego to the superego are also brought out. The many clinical pictures give the impression that the superego is from the beginning antagonistic to the ego

without explaining from the infantile and childhood history how this came about. The rôle of the œdipus complex, castration anxiety, and fear of loss of love are hardly touched upon.

RALPH R. GREENSON

Introduction to Psychotherapy. Leo H. Bartemeier. Psa. Rev., XXX, 1943, pp. 386–398.

Bartemeier calls attention to the situation at the beginning of a psychotherapeutic (not psychoanalytic) treatment. The handling of certain problems connected with the first few interviews may be decisive for success or failure. From the time of the first contact, the patient's attitudes and feelings about the psychiatrist may be of equal or even greater significance than the patient's account of his illness. These attitudes and feelings, which are beyond the awareness of the patient, comprise what might be called the preformed transference. By carefully observing its various indications, the psychiatrist is able to sense the emotional needs of the patient. The restriction of attention to the mere story of the illness may be a sign of the psychiatrist's 'counterresistance'. Inclination to premature interpretations, too, may represent a defense against anxiety on the part of the psychiatrist. A detailed case presentation illustrates the importance of recognizing the transference from the very beginning. In the case described, it was a well-concealed fear which could only be detected by a few trivial remarks, one or two aspects of the patient's behavior, and the indirect representation of his material.

BERNHARD BERLINER

Observations on the Use of Chess in the Therapy of an Adolescent Boy. Joan Fleming and Samuel M. Strong. Psa. Rev., XXX, 1943, pp. 399–416.

Improvement in an isolated, schizoid youth of sixteen took place after he became interested in chess. It provided an outlet for his hostile impulses in a non-retaliatory situation. The authors stress the dynamics in the use of the game, showing that it is a social experience which necessitates abiding by rules, taking into consideration the wishes and acts of another person, and wherein intense interpersonal relations are possible in a brief period. Good use was made of the patient's digressions from the game and his newly acquired ability to speak about his feelings, fantasies and dreams which the particular emotional situation of the game touched off. The report also demonstrates how the fact that chess is a game, and not real, enabled the patient to exert some conscious control over his feelings and thus learn to master them to a limited extent.

NORMAN REIDER

Critique of Freud's Concept of a Death Instinct. Arthur N. Foxe. Psa. Rev., XXX, 1943, pp. 417–427.

Foxe examines Freud's Economic Problem in Masochism not merely paragraph by paragraph, but at times word by word, questioning each and rejecting most if not all for reasons which remain obscure. The 'critique' should prove of value to the student of dialectics, in spite of the fact that Freud's paper has braved and survived this angry storm.

JOSEPH LANDER

Psychological Implications of the Male Homosexual 'Marriage'. Bernard S. Robbins. Psa. Rev., XXX, 1943, pp. 428–437.

Robbins suggests that individuals in whom sadism predominates as a personality trait are likely to become homosexuals. Given the presence of such sadistic drives, men turn to other men for gratification because they are unable to exploit women as successfully as they can men. The homosexual 'marriage' is overvalued, because it affords the partners the opportunity to enslave and exploit each other and simultaneously to lose their own identities in the all-encompassing relationship.

These conclusions and others were derived from the analysis of two homosexuals of utterly different personality make-up, but resembling each other in the prominence of the sadistic fantasies and the parallelism of their respective marriages.

The psychogenesis of the perverse strivings of the patients is not clarified in its details, and therefore Robbins's concern with weaknesses in the libido theory is not very convincing.

JOSEPH LANDER

Neurotic Bashfulness and Erythrophobia. Edward Hitschmann. Psa. Rev., XXX, 1943, pp. 438–447.

Hitschmann describes the development of the psychoanalytic understanding of neurotic bashfulness and erythrophobia. Inferiority feelings due to masturbation, enuresis, real or fancied physical inadequacies, were among the superficial reasons first advanced as causes of bashfulness. Further study revealed the existence of a strong scoptophilic impulse. Fear of the parent causes a repression of this impulse with the subsequent development of a masochistic tendency. This entire process is revealed in exhibition dreams, in dreams of an abashing type, of repeated failures, and of being castrated. A further source of guilt and shame is aggression displayed by many of these individuals in infancy in the form of breast biting, and in later life either in actual breast or sexual biting or in dreams thereof. The defense mechanisms involved are: repression, regression, identification with the parent of the opposite sex, and projection of the superego. The latter accounts for a certain paranoid tendency often manifested by these individuals.

ROBERT COHEN

The Drawings of an Adolescent Girl Suffering from Conversion Hysteria with Amnesia. M. Naumberg. Psychiatric Quarterly, XVIII, 1944, pp. 197–225.

This paper of Naumberg's considers a series of abstract chalk drawings made by a fifteen-year-old girl with conversion hysteria, who had developed an amnesia after her father had slapped her because she had had a date with a boy. At the mental hospital she was hypnotized and treated by psychotherapy. No attempt at psychoanalysis was made. It was then suggested to her that she use drawing as a means of expression. In these drawings she expressed emotions by colors, as, for example, anger and rage through red, depression through black, and happiness through yellow, so that she developed a consistent color language of her own. The subject matter of her drawings

is her effort to deal with her inner conflicts. She dealt with: her responses to her family (particularly to her father), her relationship to her boy friend, the transference to the psychiatrist. All of these are expressed in the form of curved color lines. The patient's art work changed with her emotional improvement.

RICHARD STERBA

Phallic Elements in Primitive, Ancient and Modern Thinking. L. R. Wolberg. Psychiatric Quarterly, XVIII, 1944, pp. 278–297.

After a review of the manifold phallic symbolisms, with their ambivalence of longing and fear, in ancient mythologies, the writer discusses their appearance in our present culture. A case is presented of a patient who had a fanatic preoccupation with 'truth' and 'knowledge'. Dreams and fantasies, in part reminiscent of the antique symbols, showed that knowledge represented his phallic sexuality which was greatly inhibited by castration fear. The writer arrives at the conclusion that as civilization progressed and interest shifted from gods and demons to abstract forms of learning and knowledge, 'progress', 'truth' and 'knowledge' have become enshrined as modern gods, and that it is possible that these abstractions are basically refined phallic symbols.

BERNHARD BERLINER

The Psychology of Ideas of Unreality with Emphasis on Feelings of Strangeness. M. D. Riemer. Psychiatric Quarterly, XVIII, 1944, pp. 316–326.

The author presents several case histories of patients with feelings of unreality, strangeness, depersonalization, or 'not belonging'. He attributes these symptoms to childhood experiences with parents who were themselves cold and removed and unable to give sufficient love to produce a sense of security in their children. By a process of transference the child assumes that all other adults are equally removed and cold. The emotional removal serves to protect the patient from further trauma which would ensue should he become involved and then rejected as he was in childhood. The illusion of superiority sometimes accompanies such isolation, and serves as a defense against the underlying feelings of inferiority or deficiency, which resulted from the original parental rejection. The psychoanalytic theories of depersonalization are not discussed.

JOSEPH LANDER

The Problem of Frigidity. Edmund Bergler. Psychiatric Quarterly, XVIII, 1944, pp. 374–390.

Typical disturbances of the frigid woman are schematically enumerated and three types are described as differing in their prognosis. The conclusions are that psychogenic frigidity is curable by psychoanalysis, the prognosis depending on the depth of the regression.

MARGRIT MUNK

The Spirogram in Certain Psychiatric Disorders. Jacob E. Finesinger. Amer. J. of Psychiatry, C, 1943, pp. 155–169.

With a special method of scoring irregularities in the spirogram tracing, Finesinger found the highest degree of irregularity in patients with manifest anxiety,

particularly as far as sighing respirations and major fluctuations (large waves in the tracings) are concerned. Lowest mean scores were found in schizophrenics and normal persons, whereas the mean values of hysterics and persons suffering from depressions fell between the extremes.

MARGARET S. MAHLER

Results of Hospital Treatment of Alcoholism. James H. Wall and Edward B. Allen. Amer. J. of Psychiatry, C, 1944, pp. 474–480.

A study of the personality and background in one hundred consecutive admissions of men treated for alcoholism at the New York Hospital, Westchester Division, revealed a number of interesting findings. There was a high incidence of alcoholic relatives. The combination of an oversolicitous mother with a successful and forceful father occurred in fifty-seven of the men. The authors found 'a passive and effeminate approach to life in forty-six'. Follow-up studies, some years later, revealed that forty-three had benefited to a significant degree, the average duration of treatment in this group being six months.

This high incidence of success in the therapy of what is admittedly a most difficult problem is not elucidated by the description of the treatment program. Though there are references to 'psychotherapeutic interviews', the major emphasis in treatment is on such methods as physiotherapy, occupational therapy, group games, etc. There is unfortunately a dearth of data on the actual dynamics either in the personalities or in the treatment.

JOSEPH LANDER

Psychoanalytic Perspectives. Edward A. Strecker. Amer. J. of Psychiatry, C, 1944, pp. 516–521.

Strecker acknowledges the merits of psychoanalysis and criticizes what he considers its weaknesses. According to him its merits are: the discovery of the impact of sexual conflicts upon human pathology, and the development of ways to help the neurotic patient to express himself. Its weaknesses are: too quick generalization, a tendency toward dogmatism and an adherence to not well-enough proven theories.

Strecker states, and rightly so, that it is not permissible to refuse scientific criticism by stating that the critic is influenced by his 'resistance'. However, he himself concludes that what he calls the 'dogmatism' of psychoanalysts is a result of their 'emotional dependency'.

GEORGE GERO

Freud's Scientific Cradle. Fritz Wittels. Amer. J. of Psychiatry, C, 1944, pp. 521–529.

Wittels describes the academic tradition in Vienna as characterized by Vienna's great medical teachers. Long before the first World War, however, the Vienna Medical School showed signs of senescence. The large family of faithful servants of the Catholic House of Hapsburg could not maintain progress. The fighting spirit, the lust to destroy, sublimated into the fight for truth, was lost. Freud was rooted in the tradition of the Vienna General Hospital. He 'really thought that a human being could exist without having an innate

philosophy'. Viennese officialdom suspected Freud because he walked ways not permitted a positivist.

MARTIN GROTJAHN

The Process of Hypnotism and the Nature of the Hypnotic State. Lawrence S. Kubie and Sidney Margolin. Amer. J. of Psychiatry, C, 1944, pp. 611–623.

The application of the theoretical development of this paper lies in the authors' contention that sensory images (olfactory, gustatory, kinesthetic, etc.), ordinarily inaccessible to verbal association, can be reëxperienced in moments of 'hypnogogic reveries'. The vividness with which the sensory images can be experienced opens the way to buried memories and their affects.

Considerable emphasis is given to the distinction between the 'process of hypnotism' and the 'hypnotic state'. The former is defined as a gradual reduction of the subject's ties to the environment until a sleeplike state is reached, the hypnotist-subject tie excepted. The hypnotic state consists of that relation wherein the subject entertains the hypnotist's voice as part of his own ego. The incorporated image (voice) of the hypnotist plays the same rôle as an 'unconscious image of the parental figure'. The description of the hypnotic state draws heavily on psychoanalytic concepts while the details of the inductive process utilizes the experimental findings of psychology and physiology to a great extent. It is to the credit of the authors that they have attempted the difficult correlation of research in the fields of psychoanalysis, psychology, and physiology to arrive at their hypotheses.

JAMES E. BIRREN

The Effect of Pleasant and Unpleasant Ideas on the Respiratory Pattern (Spirogram) in Psychoneurotic Patients. Jacob E. Finesinger. Amer. J. of Psychiatry, C, 1944, pp. 659–667.

Finesinger analyzed with his special method the irregularities in spirogram patterns in a group of sixty-four psychoneurotic patients, and compared them to a group of twenty-four normal subjects. The spirogram was taken (1) without giving the subject any directions, (2) while inducing him to think of pleasant ideas, (3) while inducing him to think of unpleasant ideas, (4) while inducing him to think of pleasant ideas a second time, and (5) while asking him to relax.

Patients diagnosed as hysteria, anxiety neurosis or reactive depression showed all kinds of irregularities—especially in reaction to unpleasant ideational stimuli. Compulsive neurotics, hypochondriacs and problematic schizophrenic patients as well as the control group showed no major changes during the 'unpleasant' period. An increase in sighing respirations as a response to unpleasant ideas, however, occurred in all groups, though in the compulsive, hypochondriac group to a lesser degree than in hysterics, anxiety patients and normal people.

MARGARET S. MAHLER

Love and Anger. Two Activating Forces in Psychoanalytic Therapy. Yzette de Forest. Psychiatry, VII, 1944, pp. 15–29.

The author, who informs us that she has been 'studying with Erich Fromm since 1942', describes as 'psychoanalysis' a procedure which deviates considerably from Freud's method.

Freud, the author states, has drawn the navigation chart of the human mind but there is still a lack of agreement as to how this chart should be used in practice. The author thinks it is best done in the following way: The human being is born with an 'impulse at creative growth'. Under today's cultural conditions, the mothers do not give the infant unconditional love, the receipt of which would be its 'birthright'. The infant responds to frustrations with the loss of its natural faith and with an increase of its hostility, called by De Forest, for unknown reasons, 'anger'.

'Love' and 'anger' are then described as Ahriman and Ormuzd (Freud's distinction of Eros and Destructiveness is not mentioned). The child becomes afraid of its anger and develops defense systems against it. Psychoanalysis must provide what was not given in childhood. In a first period, the defense systems are unmasked and the patient learns to become aware of his anger. In the second period, the patient is gradually brought to the insight in which he feels anger not only against his parents but also against his analyst. In the third period, he must be convinced that there is no reason for such anger, that the analyst does not threaten him, but rather that the analyst is a Christ, filled with altruistic interests to help the patient, and with genuine love for every patient. Two quotations may show this:

'Gradually, he came to realize that I based my life on a belief in the sincerity, the good intentions and the constructive achievements of people in general; that I believed in and counted upon human goodness. He was forced to open his eyes and see that my life was happy and productive and that I was working for his health, not only for my own pleasure but for his happiness as well.'

'It can be foreseen that the final step of his analysis will revolve around his insistence that he be given the birthright of love of which his mother deprived him when two and a half years of age; his stubborn refusal to grow up, to mature, unless this birthright be regained; his fury at realizing that under the circumstances of adult life it is lost forever; and his final determination to learn successfully how to find a substitute of his own making.'

By this treatment, a struggle between love and anger, for and against the analyst, are developed in the patient. One of the patients developed such a degree of hostility that when the analyst fell sick, he did not even come to the hospital to see him! Eventually, love wins out. The 'interpersonal relationship' to the analyst is changed from a transference into a genuine, reliable and lasting human relationship.

Thus the author's 'psychoanalysis' seems rather a kind of psychological ministry.

OTTO FENICHEL

Intellectuality in the Defense Transference. Maxwell Gitelson. Psychiatry, VII, 1944, pp. 73–86.

An attempt is made to establish the analyst-patient relationship within the framework of total life relations and to deduce from this the nature of the therapeutic problem in those narcissistic neuroses which utilize intellectuality as a major defense. In connection with this some related problems of counter-transference are discussed. It appears that it is only through the adequate management of the defense transference that the libidinal value of the analyst

as a person is established. Only when this has been accomplished can the analysis of the unconscious in the classical sense really proceed. This is particularly important in the intellectual patient who can borrow from the analyst the very means with which to come to terms with his analysis as he has previously come to terms with life. Excerpts from the analyses of two narcissistic character neuroses are presented in support of this thesis.

MARTIN GROTJAHN

On the Origin of Neurosis. William V. Silverberg. Psychiatry, VII, 1944, pp. 111–120.

The author discusses Freud's 'contention that the origin of neurosis is exclusively sexual'. Quite generally the author considers it as a serious mistake to ascribe the origin of neurosis to one single factor. He prefers a 'pluralistic hypothesis'. Many neurotic conditions may be explained on the basis 'of the frustration of effective aggression'. It is not a sacrilege to misinterpret Freud and then to go through the trouble of correcting such misinterpretation (footnote p. 120), but it is annoying to the reader to have to go with the author through complicated pathways only to find himself finally back at the starting point.

MARTIN GROTJAHN

A Projection Returns and Materializes. Fritz Moellenhoff. Amer. Imago, III, 1942, No. 3, pp. 3–13.

It is striking to the observer that the things of which the Nazis accuse their enemies—particularly the Jews—are precisely what they themselves are doing. They first projected certain inclinations of theirs onto their enemies, and this very projection made it possible for the projected wishes to 'return'. Thus Nazis now are committing deeds which otherwise would probably have been inhibited by anxiety. Moellenhoff investigates education in Nazi Germany as it is used to induce the new generation to perform the necessary projection.

This induction becomes effective through a concomitant goading of infantile narcissism, rooted in the trust in an inaccessibly powerful father, whose inaccessibility is assured by threats of castration and death. Thus 'demons' of anxiety and guilt feeling are created which, in their turn, are projected onto enemies. The author's analysis of the mechanisms in Nazi education is extremely interesting, even if we do not agree with his speculations about the part played by the 'death instinct' in this anxiety and guilt feeling. Unfortunately he neglects basic problems: for example the question of how the urge for world domination (which urge is much discussed by Moellenhoff) comes into being at all, or what conditions enable it to become effective, or the problem of what a 'nation' actually is. Moellenhoff frequently treats a nation as though it were an individual, whereas advantages and disadvantages of new ideologies are very different for different parts of the same nation. This neglect, it is true, is admitted by Moellenhoff himself: 'In historical movements and events, many factors play their part that I purposely had to neglect.'

OTTO FENICHEL

The Misapprehended Oracle. Otto Fenichel. Amer. Imago, III, 1942, No. 3, pp. 14–24.

The author's deductions about man's attitude towards oracles and forebodings are based on three experiences: (1) Freud's paper, A Disturbance of Memory on the Acropolis. (2) A patient's experience as an adolescent: 'I must always remember that girls also have legs'. (3) A pseudological patient who, afraid of illness, rubbed her thermometer in order to pretend a fever and then found out that she ran a temperature higher than her pretending efforts had aimed at.

The first two experiences have a reassuring effect in man's dealing with fate. Freud alleviated his guilt feelings concerning a success that exceeded his father's. He realized his childhood dream—to see the Acropolis—and no revengeful father or God interfered. In the second experience a patient quieted his castration fear which was linked up with the discovery of the lack of a penis in women. In the third experience the pseudological patient does not succeed in reconciling reality with her wishes. When she tried to outsmart fate, it outsmarted her.

These examples in particular and man's attitude towards forebodings and oracles in general, demonstrate how human beings are inclined to deal with fate, 'Ananke', as if it were a parental authority. Instead of realistically anticipating the unavoidable results of acting out instinctual impulses, man tries to bargain with fate in a magical sense. Intentionally misunderstanding the ambiguity of forebodings and oracles, man tries by a defiant literal obedience to shift the responsibility for his acting on to the God, on to fate, as if the inexorable Ananke could be bribed or fooled like an indulgent parent by seeming submission or atoning guilt feelings. The adjusted person finds out that, after all, his guilt feelings are superfluous, because reality follows its own laws and not the moral prescriptions of parents. The person who is estranged from reality finds his fearful forebodings verified. His rebellious instincts have challenged fate and have projected the rôle of a revengeful God onto reality.

EDITH WEIGERT

Where Child Analysis Stands Today. Beata Rank. Amer. Imago, III, 1942, No. 3, pp. 41–60.

Beata Rank's interesting paper deals in its first part with the differences between the schools of child analysis represented by Melanie Klein and Anna Freud. In the second and main part the author demonstrates her own technique in a clear, detailed presentation of the analyses of two cases. While she disagrees with the Vienna School in some theoretical points, she follows it rather closely in her practical work.

Although Beata Rank states the differences between the Vienna and the English schools, as well as her own disagreements with the Vienna School, simply and clearly, her discussion is based on papers written in 1927 and 1928; the literature between then and 1942 has clarified and revised some opinions both in respect to theory and technique.

A large part of the paper is devoted to play technique which, the author gives her reader the impression, has a rather subordinate rôle in the Vienna school. Published reports of children's analyses coming from Anna Freud's seminar give proof to the contrary. The difference between the schools as far

as play is concerned is a difference in interpretation; Beata Rank's play technique and that of the Vienna School are fundamentally the same. This is also true of the handling of the negative transference in which Beata Rank maintains that she differs from the Vienna School.

Not mentioned in this paper are the techniques used in social work and child guidance, as well as theories developed by men like Aichhorn and David Levy, all of which, though not strictly analytical, are still derived from analysis. It would be desirable to bring out the ways in which these differ from analysis in order to clarify their position.

EDITH BUXBAUM

The Respective Importance of Reality and Fantasy in the Genesis of Female Homosexuality. Edmund Bergler. J. of Criminal Psychopathology, V, 1943, pp. 27–48.

Bergler's essential thesis is that homosexuality in women is determined by a precœdipal conflict. It represents the attempt to deny the maternal rejection and simultaneously allays guilt and anxiety by choosing mother substitutes as love objects. Bergler contends that actual traumatic experiences producing such hatred cannot in and of themselves lead to homosexuality; there must also be a biologic substratum of the 'oral instinctual drive and a personality of the narcissistic-libidinous type'.

Homosexual women present what Bergler calls the 'mechanism of orality', which 'is pathognomonic for all oral neuroses and perversions'. The patients first provoke aggression from the outer world, then react violently to this aggression, and finally indulge in endless self-pity. They have strong masochistic self-destructive tendencies. If this masochism is very strong or if the unconscious guilt cannot be utilized in treatment the prognosis is poor.

The reader is struck by Bergler's pessimism regarding the male of the species: 'In reality men are fighting a desperate rearguard action; more and more they are becoming "appendages" of women'.

JOSEPH LANDER

A Psychoanalytic Study of Three Types of Criminals. R. Nevitt Sanford. J. of Criminal Psychopathology, V, 1943, pp. 57–68.

This study describes three types of criminals, differentiated according to dynamic criteria:

The presocial criminal has an undeveloped superego. His ego is relatively weak and easily gives in to strong impulses although it can inhibit them in the presence of superego prototypes. A person of this type makes a good prison inmate, but, away from surveillance, he relapses. The disorder may be due either to a weak father, whose example did not sufficiently stimulate the son's mental development or to an especially strong and aggressive father who provoked an orally dependent, passive attitude in the son. This type belongs to Freud's 'erotic' libidinal type whose need to be loved is prominent.

The antisocial criminal is characterized by an unconscious need for punishment. He has had a cruel, harsh father who maltreated his mother. He is caught in his œdipus conflict, forever trying to placate his harsh superego. He makes a troublesome inmate, yet he offers the best prospect for reform

because he is well capable of transference. He belongs to Freud's 'compulsive' type.

The asocial criminal is loyal to no ideals. He is exhibitionistic, self-assertive, boastful, friendless and offers no affection. His superego is weak, his ego relatively strong, the direction of his libido is preponderantly narcissistic. His history reveals deep narcissistic injuries: a broken home, maltreatment, neglect in early childhood, or early oral spoiling leading to inner narcissistic assurance. He is a 'hardened' criminal who can usually be influenced only by punishment.

MARGRIT MUNK

Diary of Fellatio. Terrorization and Its Unconscious Counterpart. P. Lionel Goitein. J. of Criminal Psychopathology, V. 1943, pp. 95–113.

A schizophrenic boy (age not given, but over sixteen) took part in a brutal holdup and robbery at the behest of older men to whom he was homosexually attached, his main sexual propensity being fellatio. His criminal tendencies were originally directed toward his rigid, overdisciplining father. The case, naturally not available for psychoanalysis, was studied with the help of Murray's test series for thematic apperception and a series of the patient's drawings which illustrate his unconscious. Fellatio appeared to be related to oral restitution fantasies expressed in sadistic assaults carried out on levels of urethral aggression. The solution of the œdipal conflict was attempted via inversion, sadism and identification with the enemy, and was symptomatized in stealing, fantasies and threats of killing and fellatio. Of basic importance was the unconscious equation: phallus = nipple = gun.

BERNHARD BERLINER

The Critical Moment in Psychotherapy. Maxwell Gitelson. Bulletin of the Menninger Clinic, VI, 1942, No. 6.

In this paper the author attempts to demonstrate that the psychotherapist who understands the dynamics and economics of the clinical pictures he is called upon to treat may be able to actively enter the actual situation and produce startling results. Gitelson reports on a woman with a paranoid schizophrenic episode which he was able to clear up after some ten interviews by affording her the possibility of reliving and undoing certain experiences which had precipitated the attack.

RALPH R. GREENSON

Psychodynamics of Authority with Relation to Some Psychiatric Problems in Officers. Norman Reider. Bulletin of the Menninger Clinic, VIII, 1944, pp. 55–58.

Reider observes that attitudes towards authority often present the most prominent psychological conflicts in officers. Many officers who were successful in civilian life because they were able to assume authority as a protest against authority, break down in the army when they are no longer in complete authority. Other individuals, who are dependent upon constant reassurance from higher authority, break down in the impersonal military situation. A third type of individual was able, over a long period of time, to make a rather rigid adjustment in civilian life, but is unable to make the quick changes neces-

sary in the army. There is a last group whose equilibrium is disturbed when they are promoted, because they are unable to tolerate being on an equal plane with figures they consider superior.

Reider also points out that medical officers furnish a relatively high percentage of psychiatric casualties because they lack, in army life, the unconscious gratifications which their rôle as physicians had provided in civilian life.

RALPH R. GREENSON

A Psychosomatic Study of Hypoglycæmic Fatigue. Franz Alexander and Sidney A. Portis. Psychosomatic Med., VI, 1944, pp. 191–206.

The emotional tension to which one ordinarily refers as zest, enthusiasm, or interest, keeps up a certain vegetative tonus, a certain balance in the sympathetic adrenal and parasympathetic insular tonus. This effect is qualitatively similar to that of fear and rage, but less intensive and more prolonged. Fatigue and apathy developing during routine activity without interest are not merely subjective emotional states but are based on the lack of adaptation of carbohydrate metabolism. The emotional flight reaction is called by the authors 'vegetative retreat'. The inability of the organism to raise the sugar concentration of the blood as required during activity is the immediate cause for the feeling of fatigue. This view accounts fully for the beneficial effect of atropine and of a diet containing complex carbohydrates.

MARTIN GROTJAHN

Rheumatic Disease With Special Reference to Psychosomatic Diagnosis and Treatment. Flanders Dunbar. Psychosomatic Med., VI, 1944, pp. 206–211.

Depending on the degree to which the organism-environment relation can be modified and the amount of energy bound in the somatic disorder, rheumatic patients are more or less suitable for brief psychotherapy. The treatment should be based on dynamic principles with an attempt to strengthen the ego as well as to resolve the anxiety relative to the patient's ambiguous sexual rôle. The persuasive authoritarian type of therapy usually increases invalidism. It is essential to give these patients a sense of security and the opportunity for an active outlet in a personal relationship with the doctor.

MARTIN GROTJAHN

Narcolepsy as a Type of Response to Emotional Conflicts. Orthello R. Langworthy and Barbara J. Betz. Psychosomatic Med., VI, 1944, pp. 211–226.

Patients showing the narcoleptic syndrome have in common a characteristic background of emotional conflict. They feel caught in a life pattern to which they are expected to conform, but which they deeply resent. They become motivated by a need for autonomy and for self-differentiation but are frustrated in their efforts. In the tension of the developing dilemma, the narcoleptic syndrome appears. As a result, a realistic showdown with its associated anxieties is avoided and a substitute and more acceptable source of concern is provided. At no point in their report do the authors even touch upon the problem of the specific etiology of the narcoleptic syndrome.

MARTIN GROTJAHN

A Neuropsychiatric View of German Culture and the Treatment of Germany. Richard M. Brickner and L. Vosburgh Lyons. J. Nerv. and Ment. Disease, XCVIII, 1943, pp. 281–293.

It is of course not difficult to call the National Socialistic ideology a 'paranoia', and to use this as a starting point to dress up the entire European problem in terms of 'neuropsychiatry'. The authors do this with skill, persistence, and graphic charts, the results showing all the features of such a Procrustean treatment. There is no attempt at any genetic interpretation. The therapeutic suggestions at no point leave the level of an average armchair administrator, who weeds out the really sick 'paranoia cases' (the fascists), and nurses the paranoid-reacting ones (the misled people) back to 'normality' (democratic constitution) by a kind of supervised withdrawal treatment (League of the United Nations). It may be argued that once it was a great step forward to call the criminal 'sick' instead of 'bad', and that it may be progress as well if a Nazi is called a 'paranoiac' and is treated instead of being eliminated. A superficial, unsatisfactory 'neuropsychiatric view', however, in questions of life and death—in questions which will decide the fate of generations to come—is too dangerous to allow us to appreciate such a questionable improvement in terminology.

MARTIN GROTJAHN

Physiology of Schizophrenic Thinking. G. Bychowski. J. Nerv. and Ment. Disease, XCVIII, 1943, pp. 368–387.

Schizophrenic thinking is archaic thinking. This is not only true in the sense of a similarity between the thinking of schizophrenics and of infants, but also in the sense that the functions of certain higher regulating centers cease or diminish. Schizophrenic thinking points to the functioning of deeper, subcortical parts of the brain, those which are responsible for cataplexy.

Bychowski contributes a detailed analysis of a few excerpts of a case history and adds an exact description of the methods of schizophrenic thinking with stimulating speculations as to the underlying physiological processes.

OTTO FENICHEL

Dissolution of the Ego, Mannerism and Delusion of Grandeur. Robert C. Bak. J. Nerv. and Ment. Disease, XCVIII, 1943, pp. 457–464.

The author bases the thesis of this paper on Freud's concept that many of the symptoms of a schizophrenic psychosis represent an effort toward self-cure, while the process of the illness, unobtrusive in most cases, eludes observation. In agreement with some French and German psychiatrists, Bak considers the essential schizophrenic process as a regression into the archaic family unit and a dissolution of the ego, which may be experienced as an overflowing of the personality into the outer world. In the battle against this dissolution of personality the symptoms of mannerism and delusion of grandeur represent reintegrative efforts. The mannerisms emphasize the patient's wish to be different from others; the delusions of grandeur, more markedly still, enhance the patient's personality and set him apart from the masses. In prepsychotic or schizoid

personalities the same symptoms, in a milder degree, may have a preventive function in anticipation of the danger of a dissolution of the ego.

The paper represents a contribution to a unifying interpretation of schizophrenic symptoms.

EDITH WEIGERT

The Pubertal Struggle Against the Instincts. Joseph Lander. Amer. J. of Orthopsychiatry, XII, 1942, pp. 456–462.

In this paper the author contrasts the emotional development of normal children with that of delinquents. The normal child spends the first five years of life in satiating his sexual and aggressive impulses; he also learns to master them through the development of defense mechanisms and through identifications with the friendly adults in the family. Successful completion of this process, together with the physiological decline in instinct strength which occurs at the age of five, leaves the individual free during the latency period to devote himself to activities which strengthen the ego. He turns his energies to the acquisition of knowledge, to new ways of achieving recognition and gratification, and to attempts at acquiring a feeling of group identification. The increased energy produced by the maturing gonads at puberty faces the child again with his old problem of mastering instinctual drives. The delight in dirt, gluttony, peeping, masturbation, untidiness, and moodiness, so typical for the adolescent, represent attempts at defense against instinct.

The delinquent is unable to achieve the balance which normal children ultimately acquire. A frustrating environment in his early years leaves him with his instinctual drives unsatisfied at the beginning of the latency period. Consequently, he is unable to renounce them like the normal child and continues to seek infantile modes of gratification. He thus has little energy available for ego strengthening activities. Since he expects other people to be as hostile and frustrating as his family, he is unable to make those identifications and social ties which strengthen the ego of the normal child. At puberty, the delinquent has no reserve of defense mechanisms and character strengths with which to meet the accession of instinctual energy.

Treatment of the delinquent adolescent is so difficult because there is so small a residue of healthy personality with which to work. The author believes that the therapist should deliberately foster a strong dependent transference which can then be used to exploit the areas of health which still remain. One should not hope to achieve a complete reconstruction of the personality. If therapy succeeds only in erecting internal barriers against delinquency, this is a partial success, even though it may involve the production of a neurosis. Really constructive efforts lie in the field of prevention. The early unhealthy family situation is largely unmodifiable; during the latency period, however, social and educational measures can give them 'the tools they will need to help them ride out the storm that lies ahead at puberty'.

A. H. VANDER VEER

Collaborative Psychiatric Therapy of Parent-Child Problems. Stanislaus Szurek, Adelaide Johnson, Eugene Falstein. Amer. J. of Orthopsychiatry. XII, 1942, pp. 511–517.

This study from the Institute for Juvenile Research in Chicago emphasizes the unconscious gratification which the parent derives from his child's neurotic

symptoms. A number of brief examples illustrate this thesis. One mother induces her son to attack her so that she may enjoy the pain of a twisted arm; another mother unconsciously fosters and enjoys a seductive relationship between her daughter and her husband; while a third mother provokes her daughter into burning the apartment, thus vicariously acting out her own repressed wishes to kill her family by fire. In most of the examples cited, the identification of the provocative parent with the child is obvious. The authors believe that their observations cast some light on the vexing question of symptom choice and also on the origin of behavior problems in twins. In several instances they show that a parent's veiled hint, dire prediction, expressed aversion, or overanxious reaction was utilized by the child as a cue to canalize his conflicts into some typical mode of problem behavior. The parent's secret gratification accounts, in part, for the long delay between the onset of neurotic symptoms in a child and his appearance at a clinic. So long as the parent does not feel too much social pressure or too much guilt because of his child's misbehavior, the symptoms are ignored. When the guilt or social pressure increases to an uncomfortable degree, or when the child's secondary gain outweighs that of the parent, then the latter takes action. In the sets of twins who were seen, it was noted that one of the parents encouraged the expression of his own ego-syntonic impulses by one twin, and of his ego-dystonic impulses by the other. The latter twin was considered ill by the parent.

Their experiences have led Szurek and his colleagues to evolve a technique of 'collaborative therapy' in which the child is treated by one psychiatrist and the significant parent by another. This approach is not without its difficulties, since the therapists must keep their own competitive tendencies under strict control. The authors believe that most acting-out behavior problems and serious neuroses in children from five to adolescence are amenable only to this type of treatment; only thus can the causative distorted interpersonal relationships be rectified at both ends. Collaborative therapy demonstrates the futility of giving advice, for a neurotic parent obviously cannot take any real stand against his child's symptoms.

These observations add a dynamic rationale to the classical 'team-treatment' of child guidance. Although the authors highlight one cause of neuroses in children, they do not overlook the fact that the child is an individual and more than a mere resonator for his parents' ids.

A. H. VANDER VEER

Psychiatric Care of Children in Wartime. Elisabeth R. Geleerd. Amer. J. of Orthopsychiatry, XII, 1942, pp. 589–594.

The author's conclusions are based on first-hand experience with young English and continental refugees during the Blitz. She singles out four factors which may disturb the mental health of children during wartime. The first traumatic situation occurs when the father enters military service. His absence prevents a proper solution of the œdipus complex for any child: when children remain tied to the mother, they tend to experience disturbances in object choice later on, the boy unconsciously attempting to get a mother instead of a wife, and the girl tending to be fixated on homosexuality. The father's absence may also create superego pathology in both sexes since the strongest impeteus to stable superego development is lacking. Finally, the

potential danger to the father in war may increase guilt feelings in the children.

The second traumatic situation is created when the mother goes to work. Any child tends to regard such an act as a withdrawal of love, and it may therefore regress to wetting, soiling, and infantile demands. The lack of supervision also makes it easier for children to engage in antisocial behavior. The author suggests that these two disturbing situations can be ameliorated by a sort of substitution therapy. Children should be provided with adult male companionship in the form of teachers, scout masters or group leaders to compensate for the father's absence; day nurseries, play groups under female supervision, or contact with women social workers may furnish adequate substitutes for the working mother's care.

A third factor of possible importance is the bombing raid. Geleerd quotes Anna Freud and her own experience to prove that children are not disturbed by bombs if they stay with their parents and if the latter remain calm. Most children who were seen by the author shortly after various harrowing experiences showed no shock, anxiety, or nightmares. An anxious child may, however, weave ideas about air raids into its neurosis. Thus, to some children, air raids symbolize an aggressive sexual attack, as was demonstrated in the analysis of one little girl. This child defended herself against her fear of assault by identifying with the aggressor, Hitler. She used to say: 'I am Hitler because I am afraid Hitler is going to drop bombs and kill me.' In the rare instances where children did suffer actual bomb-shock, they usually were too anxious to talk about what had happened. The author feels that such cases should be urged to abreact the horrifying events in speech or play.

The fourth situation, evacuation, is traumatic for children only if it involves a sudden separation from the mother. Geleerd cites various British studies which showed that children who were evacuated alone developed anxieties, depression, bed wetting, and a rather marked feeling of guilt because they were safe while their parents were in danger. The conclusion is drawn that evacuation usually secures physical safety for the child at the expense of its mental health. The author again quotes Anna Freud to demonstrate that separation from the mother is well tolerated if it can be carried out gradually over a period of a few weeks. She suggests some measures which would permit evacuation with a minimum of anxiety. Children might be taken to an area sufficiently close so that the mother could visit regularly. Alternatively, whole schools might be sent to camps where they could live in cabins with mother and father figures, thus preserving a sort of family constellation. Finally, the author emphasizes the extreme importance of regular school attendance for children in wartime, whether they are evacuated or not, since the school is one of the stabilizing influences which prevents antisocial behavior.

A. H. VANDER VEER

The Effects of Incest on the Participants. Paul Sloane and Eva Karpinski. Amer. J. of Orthopsychiatry, XII, 1942, pp. 666–674.

Three cases of father-daughter incest and two of brother-sister incest are the subject of this report. The incestuous experiences all occurred after the girls had reached puberty, and in four out of the five a pattern of later promiscuity became firmly established. The authors speculate regarding the psychodynamics

involved and emphasize guilt-feelings towards the mother, the tendency towards neurotic 'acting out', and the difficulty in restricting adolescent sexual impulses, once gratification has taken place. They raise questions as to why the incest barrier broke down in these cases and conclude that the causative factors were: the lax morals of the community, a defective superego, and the assumption of responsibility by the male. They contrast their findings with those of Bender and Blau, who concluded that sexual relations with adults were not necessarily traumatic when they occurred in the years before puberty.

A. H. VANDER VEER

Bulletin of the U. S. Army Medical Department, IV, No. 2, 1945, pp. 133–137.

Psychotherapy With Pentothal Narcosis requires psychiatric understanding and cannot be employed successfully as a means of reducing anxiety as though anxiety were a substance to be drained off. There must be an attempt to synthetize, using the assets of the personality after the stressful situation has been abreacted. The emphasis on the value of abreaction may lead to the assumption that it is the focal point of treatment, to the exclusion of matters which may be of greater significance. The patient may find it much easier to dwell on his combat experiences than on other current [or infantile, Ed.] situations. The psychiatrist may fall into this trap and be kept from discovering frustration which prevents recovery.

Psychiatric Nomenclature represents a conglomerate of terms with a wide latitude of classification of psychotic responses and a very limited and rigid classification of neurotic responses. Even among psychiatrists, there is a widespread lack of uniformity in the interpretation of various diagnostic categories. The Neuropsychiatry Consultants Division of The Surgeon General's Office, in attempting a revision of the diagnostic terminology, has held numerous conferences and solicited widely the opinions of leading psychiatrists in military and civilian life.

The term 'psychoneurosis' is to be dropped from the individual clinical records in army medical installations. In its stead, the physician will designate the specific type of psychoneurotic response, such as 'anxiety reaction', 'conversion reaction', 'compulsive obsessive reaction'. In addition to this term designating the syndrome, a brief statement on the personality structure and predisposition will be made, a brief statement on the external precipitating stress in the present illness, and finally an evaluation of the functional capacity of the individual to carry on in his last assignment. By this method it is believed the psychiatrist will of necessity be more specific and will be required to formulate a more complete picture of the patient in terms understandable even to a layman.

Psychoneuroses Among Officers is a matter of grave concern, not because of their frequency, but because of the effect they have on the other personnel of an organization. There are officers, temperamentally anxious, who in a comparatively short time develop exhaustion [transient anxiety states, Ed.] or a psychoneurosis during periods of battle. Such cases should be reclassified before harm is done, and all commanders must be vigilant to detect such cases by visiting regimental commanders, and as many battalion and company commanders as possible, daily during combat. Officers who are reclassified because

of mental instability or inability to stand the pressure of combat are usually undesirable as officers in any capacity. Best results are obtained when there is a very close relationship between neuropsychiatrists, the inspector general, and the division commander. Good psychiatrists should be placed in officer candidate schools to examine candidates throughout the course with a view to eliminating those who are unsuitable before they are commissioned.

R. G.

The Marihuana Addict in the Army. Eli Marcovitz and Henry I. Myers. War Med. V, 1944, pp. 382–394.

Thirty-five marihuana addicts—seen at the Army Air Forces Hospital at March Field, California—had without any exception an extremely adverse familial, social and economic background. Their personalities were in accordance with the 'addict type' as described by psychoanalytic theory. They were full of strivings for immediate and constant gratification of sensual as well as self-esteem needs, incapable of tolerating anxiety or any other tension. The use of the drug created a vicious circle, making the patients still less capable of standing life without it. The importance of adverse external circumstances as a contributing factor in forming the character which leads to addiction is so striking that the authors recommend: 'that government institutions be created to which such confirmed marihuana addicts may be committed for long term treatment and rehabilitation or for indefinite custody'.

OTTO FENICHEL

Theoretical and Practical Aspects of Psychoanalytic Therapy of Problem Drinkers. Simon Weijl. Quarterly J. of Studies on Alcohol, V, 1944, pp. 200–211.

The author reviews some of the psychoanalytic literature on alcoholism, including one of his own former contributions. He discusses the œdipus complex of alcoholics (the father is destructively 'introjected' and the mother taken into possession); their unconscious oral attachment to the mother; the fact that drinking gives a feeling of strength and superiority, which means a father identification (as can be seen in the use of alcohol in initiation rites); and the importance of homosexuality. The sublimation of this homosexuality forms the basis of the therapeutic influence of Alcoholics Anonymous and of sports.

BERNHARD BERLINER

Hypertension in Only One of Identical Twins. Report of a Case with Consideration of Psychosomatic Factors. Meyer Friedman and J. S. Kasanin. Arch. of Internal Med., LXXII, 1943, pp. 767–774.

One of a pair of identical twins suffered from hypertension and coronary artery disease, whereas his brother was healthy. The clinical evidence suggested that psychological factors may have been of primary significance in the production of hypertension in the affected twin. The case studies of the patient and his twin brother in their similarities and contrast are very interesting.

MARTIN GROTJAHN

A Study of Treason. A. M. Meerloo. Brit. J. of Psychology, XXXV, 1945, pp. 27–33.

Dr. Meerloo of the Hague, Netherlands, who escaped to England, bases his paper on personal life experiences under Nazi domination. No traitor admits his treachery; he has to justify his conduct. Many traitors are disappointed, frustrated people with a grievance, desirous of taking their revenge on society. Often they have serious neurotic abnormalities such as homosexual tendencies, or in some cases strong mother fixations which they have transferred on their country. A dangerous temptation to everyone is the tremendous desire to be associated with power. Treachery means a rationalization of uncontrolled instincts. According to Meerloo, 'It consists in the failure to pay due regard to our inner processes, the denial of our own moral code. Every betrayal is fundamentally a self-betrayal.' The ambivalent emotions of adolescence are its basis. A sense of guilt is one of its sources and thus a vicious circle develops. Meerloo hopes that a democracy which gives the opposition full freedom may create a sense of responsibility and thus, as it involves an educative process, may be able to eradicate psychological unbalance in the future.

HENRY LOWENFELD

La Despersonalización Desde el Punto de Vista de la Psicopatológia General. (Depersonalization From the Point of View of General Psychopathology). E. Eduardo Krapf. Rev. de la Univ. de Buenos Aires (Tercera Epoca), LIX, No. 2, March 1944.

Krapf examines depersonalization with phenomenological methods, trying to establish its relation to derealization and to determine the significance of both syndromes. Using Scheler's psychology of feelings, he describes depersonalization and derealization as disorders in the emotional sphere which are subjectively perceived in the intentional references of ego states towards the body and the outside world. He finds the phenomenological data in accordance with the psychoanalytic interpretation of depersonalization as a narcissistic withdrawal of libido. Finally he tries to express the pathological experience in terms of the psychology of time and space.

ANGEL GARMA

NOTES

The SALMON COMMITTEE ON PSYCHIATRY AND MENTAL HYGIENE announces that Dr. Roy Graham Hoskins will deliver the Salmon Memorial Lectures for 1945 on the three successive Friday evenings of November 2d, 9th, and 16th, at the Academy of Medicine of New York City. The Biology of Schizophrenia is the title of the series.

Dr. Hoskins is Research Associate in Physiology, Harvard Medical School; Director of the Memorial Foundation for Neuro-Endocrine Research, Boston; and Director of Research at Worcester State Hospital.

The ILLINOIS PSYCHIATRIC SOCIETY, at its annual meeting, elected the following officers for the year 1945–1946: Dr. John J. Madden, President; Dr. Frances Hannett, Vice-President; Dr. Charlotte G. Babcock, Secretary-Treasurer; Drs. David Slight and Edward P. Ross, Councilors.

A psychiatric clinic will be established at UNIVERSITY HOSPITALS, WESTERN RESERVE UNIVERSITY, to provide treatment for civilians at a nominal fee and free treatment for servicemen and their families who are referred there by the American Red Cross. The clinic is made possible through the Greater Cleveland Red Cross chapter, which has procured financial support for the part of the program applying to servicemen and their families. It is anticipated that some support for the civilian part will be sought later through a public campaign. The clinic will be staffed by five psychiatrists, one psychologist, and psychiatric social workers and nurses. It will be housed temporarily in Lakeside Hospital and eventually in a new psychiatric building which will adjoin the other hospitals of the university group on Western Reserve campus.

DR. SUSANNA S. HAIGH wishes to make the following correction: 'A misstatement was made in my review of Dr. Oberndorf's book, The Psychiatric Novels of Oliver Wendell Holmes, which appeared in the April 1945 number of THE PSYCHOANALYTIC QUARTERLY, namely, "One error has crept into the main introduction in the statement that Professor Freud's Introductory Lectures were given in the United States". The statement made by Dr. Oberndorf was as follows: "Freud's lectures delivered at Worcester, Massachusetts, have become classics for students of psychoanalysis. . . ." I was wrong in assuming that Dr. Oberndorf had confused the five lectures given in Worcester with the better known series given in Vienna.'

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